CARE in Bolivia

Center for Investigation, Education and Service (CIES)

MID-TERM EVALUATION REPORT

MARKET NETWORKS FOR COMMUNITY HEALTH

CHILD SURVIVAL X - I'N26

Prepared and Submitted by:

Sandra Wilcox and Jim Becht

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LIBT OF ACRONYMS

CBD	Community Based Distribution
CDC	Centers for Disease Control
CDD	Control of Diarrhea1 Disease
CIES	Center for Investigation, Education and Services
CSSP/JHU	Child Survival Support Program/Johns Hopkins University
DIP	Detailed Implementation Plan
ENDSA	National Demographic and Health Survey
FPLM	Family Planning Logistics Management
HIS	Health Information System
IEC	Information, Education and Communication
INE	Bolivian National Statistics Institute
INLASA	Bolivian National Laboratory Institute
IUD	Intrauterine Device
JHU/PCS	Johns Hopkins University/Population Communications Services
LAM	Lactation Amenorrhea Method
NGO	Non-Governmental Organization
ORS	Oral Rchydration Solution (or Salts)
ORT	Oral Rehydration Therapy
PROCOSI	Coordination Program for Child Survival Non-governmental Organizations
PSI	Population Services International
PVO	Private Voluntary Organization
RTA	Regional Technical Advisor
SOH	Secretariat of Health
STD	Sexually Transmitted Disease
USAID	United States Agency for International Development
WRA	Women of Reproductive Age

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Mid-Term Evaluation Report
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I ACCOMPLISHMENTS

A. PLANNED OBJECTIVES, OUTPUTS, AND INPUTS

1. Project Implementation Period

The mid-term evaluation is taking place 20 months into the planned three year project; 55% of the project time has elapsed. Although project start-up was slow during the first 10 months due to an early decision by project personnel to sub-contract the program to the counterpart NGO (CIES) and subsequent delays in subagreement approval by USAID in Washington, the project staff has been working.. very hard during the past 10 months to catch up the implementation of project activities as originally planned.

The stated project objectives, outputs and planned inputs are as follows:

2. Family Planning (FP) - 70% of Project effort

Family Planning Primary objective: Increase from 10.6% to 30% the number of women of reproductive age who are not pregnant, who desire no more children in the next two years and who are using a modern contraceptive method.

The planned inputs for this objective include:

* Training courses I and II for project personnel
* Training courses I and II for CBD volunteers
* Ethnographic study
* Referrals to the CIES clinic
* Sale of condoms
* Sale of pills
* Sale of vaginal tablets

The planned outputs as noted in the DIP are:

* Number of acceptors to a modern method
* Number of methods distributed:
  - 565,425 condoms
  - 24,518 cycles of pills
  - 166,238 vaginal tablets
  - 3,648 IUD referrals

Family Planning Knowledge Objectives: Increase from 61.7% to 90% the number of women of reproductive age who have knowledge of at least three modern methods of family planning.

Planned Inputs: IEC activities

Planned Outputs: number of persons informed through individualized counseling, talks: 21,800 WRA

Knowledge Objective a): Increase from 70% to 90% the number of women of reproductive age who have knowledge of pills as a contraceptive method.

Planned Inputs: IEC activities. Distribution through CBD volunteers, using market networks.

Planned Outputs: Number of persons informed through individualized counseling, talks: 8,600 WRA.

Knowledge Objective b): Increase from 59% to 90% the number of women of reproductive age who have knowledge of condoms as a contraceptive method.

Planned Inputs: IEC activities. Distribution through CBD volunteers, using market networks.

Planned Outputs: Number of persons informed through individualized counseling, talks: 16,700 WRA.

Knowledge Objective c): Increase from 65% to 90% the number of women of reproductive age who have knowledge of IUD as a contraceptive method.

Planned Inputs: IEC activities. Distribution through CBD volunteers, using market networks.

Planned Outputs: Number of persons informed through individualized counseling, talks: 12,300 WRA.

Knowledge Objective d): Increase from 14% to 60% the number of women of reproductive age who have knowledge of rhythm as a contraceptive method and who know that a woman is most fertile half way between menstruations.

Planned Inputs: IEC activities. Distribution through CBD volunteers, using market networks.

Planned Outputs: Number of persons informed through individualized counseling, talks: 33,700 WRA.

3. Sexually Transmitted Diseases (STD) - 15% of effort

STD Objectives:

1. Increase from 58% to 80% the number of women of reproductive age who know that sexually transmitted diseases exist and who can name at least one.

2. Increase from 75.3% to 85% the number of men 15 years and older who know that sexually transmitted diseases exist and who can name at least one.

3. Increase from 38% to 75% the number of women of reproductive age who know that sexually transmitted diseases can be prevented by using a condom, having sexual relations with one partner who is also faithful, or abstinence.

4. Increase from 54.7% to 75% the number of men 15 years and older who know that sexually transmitted diseases can be prevented by using a condom, having sexual relations with one partner who is also faithful, or abstinence.

Planned Inputs for all STD Objectives:

* Training course III for all project personnel.
* Training course III for CBD volunteers.
* Ethnographic study.
* Referrals to CIES clinic.
* Sale of condoms.
* IEC activities.

Planned Outputs for all STD Objectives:

* Project personnel (2 educators, 4 CBD Supervisors and assistant project manager) trained in course III for project personnel.
* 150 CBD volunteers trained in course III for volunteers.
* Number of persons informed through individualized counseling.
* number of persons referred to CIES clinic.

4. Control of Diarrhea1 Diseases (CDD) - 15% Of effort

The diarrhea1 disease component has two primary objectives, one directed at increasing the knowledge and skills of-mothers of children less than 24 months of age, and the other directed at improving the management of diarrhea in children less than 24 months. In response to comments from the technical reviewers of the DIP, project staff agreed to modify the "ambitious" objectives of the CDD component as follows. (The revised objectives were stated in the first annual report; the percentages given in parentheses are those stated in the DIP.)

Primary Objective One: Increase from 52% to 65% (70%) the number of mothers who have used oral rehydration therapy (ORT). This objective has five sub-objectives:

1.a Increase from 27.7% to 40% (70%) the number who know that ORT is used to prevent dehydration.

1.b Increase from 51% to 65% (70%) the number who know how to prepare ORT packets correctly (1 liter of boiled, cooled water with 1 ORS packet).

1.c Increase from 19.7% to 30% (60%) the number who know that it is necessary to give more fluids than normal when the child has diarrhea.

1.d Increase from 36% to 50% (60%) the number who can recognize signs of dehydration as an indication that they need to seek help.

1.e Increase from 43.7% to 55% (60%) the number who know that it is necessary to give a child more food than usual when the child is recovering from an episode of diarrhea.

Primary Objective **Two:** Increase from 24.1% to 50% tunchanaed) the percent of children who were treated with ORT **(packets** or home solution) durina the diarrhea **episode.** This objective has three sub-objectives:

2.a Maintain at 84.2% or increase the percent (unchanged) who are breastfeeding who breastfedthe same or more frequently during the diarrhea episode.

2.b Increase from 62.7% to 75% (80%) the percent of children who were not exclusively breastfed who were given the same amount or more fluids (breast milk excluded) then normal.

2.c Maintain or increase the percentage (67.6%) of children who were given the same amount or more food during the diarrhea episode.

The planned **inputs** for all CDD objectives include:

* Training course IV for project personnel (40 hours in year 1, and 8-hour in-service refresher courses in years 2 and 3);
* Training course IV for CBD volunteers (50 per year receive 16 hours in-service training each); and
* Provision of ORS packets.

The planned outouts for all CDD objectives include:

* Project personnel (the assistant project manager, 2 coordinators and 4 CBD supervisors) trained in basic elements of diarrhea1 disease control (Course IV);
* # people reached by IEC (community education) activities;
* # referrals of acute cases to the CIES clinic by CBD volunteers and project personnel.

B. ACHIEVED INPUTS AND OUTPUTS

1. Family Planning

Personnel training:

At the time of the mid-term evaluation, the project personnel (project deputy director, 2 coordinators, 4 supervisors) had received training in :

* Basic family planning (course I)
* Family planning counseling and interpersonal communications (course II)
* Active participatory educational techniques (course II)
* STD/AIDS (course III)
* Control of Diarrhea1 Disease (CDD course IV)
* Refresher course for family planning, STD/AIDS, CDD

Volunteer training:

At the time of the mid-term evaluation, volunteer promoters had received the following training courses:

* Basic family planning (course I), seven courses provided by project. 163 promoters trained. (93% of number targeted)

* STD/AIDS (course III), two courses provided by project. 62 promoters trained. 2 more courses planned for yr 2.

* CDD training (course IV). 2 courses provided. 29 promoters trained. (2 more courses planned for yr 2).

Ethnographic study:

The ethnographic study planned for the first year is still in process. Due to the delays in approval of the subcontract, work did not begin on the study until year 2. The purpose of the study is to assure that the project's approach and IEC strategy are culturally appropriate for the target audience. The project wants to adequately address cultural constraints to family planning and the use of modern health services.

At the time of the mid-term evaluation, two field reports had been completed from three neighborhoods of the two project districts. Qualitative data about attitudes and knowledge of family planning, STDs and CDD are described in the documents.

Promotional Activities:

AS early as May 1995 (project month 8), project staff initiated a

series of promotional activities designed to increase awareness of CIES clinic services and the CBD program among the target population, to recruit CBD volunteers, and to identify community groups through which to provide IEC activities. These activities, consisting of house-to-house visits and presentations at community fairs, were not specified in the DIP but were mentioned in the first Annual Report.

Between May 1995 and April 1996, staff made presentations at 57 fairs and during 54 home visiting circuits which reached all but three of the 29 target neighborhoods (see Table 2 in Annex E). Over three-fourths of the promotional activities were undertaken in the second project year (between October 1995 and April 1996).

Referrals:

At the time of the mid-term, the project has had the following referrals (through second quarter yr 2):

*	315 for IUD,	45% of target
*	232 for the pill	56% of target
*	39 for depoprovera	58% of target
*	187 for STD referrals	38% of target

Sale of Condoms

* 342,257 condoms sold through second quarter yr. 2 (155% of target).

Sale of Pills

* 689 (cycles) sold through second quarter yr. 2 (21% of target)

Vaginal tablets

* 26,380 sold through second quarter yr. 2 (92% of target).

Number of methods distributed **in relation to outputs delineated in** the DIP:

	DIP	Methods Distributed	
Condoms:	565,425	342,257	61%
Pills:	24,518	689	3%
Vaginal Tabs:	166,238	26,380	16%
Ref for IUD:	3,648	315	9%

IEC Activities:

Through the second quarter of year 2 the project had achieved the following educational and informational outputs:

Home visits:	22,994,	88% of target
Counseling sessions:	1,670,	77% of target
Community education talks:	202,	93% of target
Female participants:	3,762	
Male participants:	2,080	
Total participants:	5,842,	99% of target
Talks by subject:		
FP & CA:	159,	80% of target

A total of 159 educational activities were undertaken between June 1995 and April 1996. Family planning talks were presented on 113 occasions in 24 neighborhoods, and cancer awareness talks were given 46 times in 20 neighborhoods. These talks represent 78.7% of all community IEC activities to date. (See Table 3 in Annex E).

2. Sexually Transmitted Diseases

IEC Activities:

A total of 31 educational activities on STD/AIDS awareness were given in 15 project neighborhoods between September 1995 and April 1996. These activities represent 15.3% of all community IEC activities to date. (See Table 3 in Annex E).

Referrals:

As of April 1996, a total of 211 referral were received at the CIES clinic for STD services. This represents 34% of the target.

3. Control of Diarrhea1 Diseases

Staff Training:

The seven (7) project staff received training in basic CDD in September 1995 (project month 12). Staff had a refresher course covering all project interventions in May 1996. Course IV (CDD) content focused on: the importance of ORT in diarrhea1 disease management; recognition of the symptoms of dehydration; protocols for referring complicated cases to the health center; and methods and techniques for educating mothers on symptoms of dehydration, the use of ORT, dietary management of diarrhea, and prevention.

Provision of OR6 Packets:

The training of CBD volunteers in the control of diarrhea1 diseases was delayed until ORS packets could be obtained from the Regional Secretariat of Ilealth in El Alto. The first order of ORS packets was scheduled to be available in December 1995. A supply of 3,700 packets (the estimated need for'the first six months) was secured in March 1996 (project month 18). The project expected to

distribute at least 600 packets to mothers of children with diarrhea by June, but numbers related to actual ORS use has not yet been reported in CARE's quarterly implementation reports (PIR).

IEC Activities:

Community IEC activities were begun only recently by project staff in March and April of 1996. A total of 12 group presentations, representing 5.9% of all educational activities to date, were given in four of the 29 project neighborhoods (see Table 3 in Annex E). The number of women and men attending these CDD activities was not readily available from project reports.

Referral of Cases:

In April 1996, the first seven (7) cases of diarrhea were referred to the CIES clinic for treatment. Interviews with CBD volunteers during the present evaluation suggest that most cases of diarrhea and dehydration are being referred to the SOH (RSH), PROSALUD (an NGO), or church-affiliated clinics which are located in the project neighborhoods.

CBD Volunteer Training:

The first two CDD courses, training a total of 29 CBD volunteers, were given in March 1996 (project month 18). The total number of CBD volunteers trained to date represent 29% of the 100 planned (in the DIP) to be trained in CDD by June 1996. Two more courses are planned for the July-September quarter. CDD course content includes: general concepts of diarrhea1 disease in children; complications of diarrhea including symptoms of dehydration; importance of dietary management; oral rehydration therapy (ORT); and preparation and administration of oral rehydration solution (ORS packets).

C. OUTPUTS COMPARED TO OBJECTIVES AND EXPECTATIONS

1. Family Planning

Regarding the primary family planning objective, the CARE-CIES CBD Project states that at the end of the three years 30% of the beneficiary population which includes 44,537 women of reproductive age in the El Alto districts where the project is located, will be using a modern contraceptive method. It was determined by the Knowledge and Practice baseline survey conducted at the beginning of the project, that 10.6% of women of reproductive age (who were not pregnant and desired no more children during the next 2 years) in the project area were already using a modern method of family planning. Therefore, the project would have to demonstrate an increase of 19.4% in use of' modern methods among women of reproductive ages in the project area. The corresponding figures

are:

Beneficiary Population:	44,537
30% of Beneficiary Pop:	13,361
10.6% of Beneficiary Pop:	4,721
19.4% of Beneficiary Pop:	8,640

Given that it was decided by project personnel not to repeat the baseline survey at the time of the midterm evaluation, it is not possible to determine progress from such an instrument at this time. However, according to the figures supplied by project documents at the midterm evaluation we can infer that the project is close to reaching its primary objective. The report on the self evaluation workshop held by project personnel in May of 1996 notes that during the 20 months of project activity, the CBD project has provided family planning services to 8,882 new users in the project sites. This represents roughly 20% of the beneficiary population.

According to CIES, the definition of a new user is a method user who is new to CIES, so it is unclear whether the person has used a family planning method before. If the new users have never used a family planning method before one could conclude that with this increase of 20% of new users then the project has already reached its primary objective of increasing modern method use among WRAs from 10.6% to 30%. However, if the new user has been a previous user of modern methods then the percentages would fall between 20% and 30% of the population. Again, this is an inferred conclusion and to really measure impact, it will be necessary to compare the results of the final Knowledge and Practice baseline survey. However from progress to date of having probably reached between 20% to 30% of the beneficiary population, we can feel confident that the CBD project will reach its primary objective.

The other family planning objectives have to do with increasing knowledge about contraceptive methods among the WRA of the beneficiary population. Again without a repeat baseline survey, it is difficult to determine how close the project is to meeting these objectives. However the outputs designated for reaching these knowledge objectives are numbers of counseling sessions and educational talks given to WRAs of the beneficiary population. The objectives set different targets for knowledge to be gained by WRAs about each method. They range from 8,600 women who will be informed about the pill to 33,700 who will be correctly informed about the rhythm method. Unfortunately, program documents are not broken down by numbers of women informed per method. However, according to the May 1996 self evaluation report, in general 22,994 women have been educated about methods through home visits, 1613 through counseling sessions, and 3,762 through group talks. This is a rough total of 28,369 women that have been reached through education and counseling sessions about all methods. Other evidence suggestive of increased knowledge of family planning is noted in the CIES

service statistics for the first year of the project. There was a dramatic increase in community based distribution (CBD) services between 1994 (the year before services began) and 1995 (when the CARE/CIES project began distributing methods). In 1994 the CBD program distributed to 4,794 new users in El Alto. In 1995 the CBD program reached 8,062 new users. This represents a 68% increase in use of El Alto CBD services.

In conclusion, given the large number of women that have been educated through the CARE/CIES program and the dramatic increase in CBD services since the project has begun in El Alto-; we can infer that the project is making good progress towards reaching its increased knowledge objectives. However, the exact levels of increased knowledge per contraceptive method will have to be determined through the final Knowledge and Practice baseline survey.

Promotional Activities:

Promotional activities carried out by project supervisors and coordinators appear to be very beneficial for raising community awareness of the services offered by CIES, for helping staff become familiar with project neighborhoods, and for recruiting. CBD volunteers. It is, however, a time consuming effort. By reviewing maps on which supervisors track the areas covered by these activities, it appears that during the ten months the promotional activities have been undertaken only lo%-20% of the project area has been visited. The maps themselves are not always accurate since El Alto is a very rapidly growing area with little urban planning.

An analysis of where promotional activities have been carried out reveals an uneven level of effort. Table 2 and Figure 2 in Annex E shows the number of promotional activities carried out in each project neighborhood. The activities are also compared to the population residing in each neighborhood in order to calculate a ratio of coverage. Project staff have concentrated their efforts in eight neighborhoods, while three neighborhoods have not been visited at all and another nine have been significantly underserved.

Educational Activities:

Project staff have conducted 202 community-based education activities, almost 80% on family planning and cancer awareness topics. An analysis of where the educational activities have been carried out reveals an uneven level of effort. Table 3 and Figure 3 in Annex E shows the distribution of these activities in the various project neighborhoods. These activities are also compared to the population residing in each neighborhood in order to calculate a ratio of coverage. Four of the project neighborhood6

have not received any educational activities and another nine have been significantly underserved to date.

2. Sexually Transmitted Diseases

The project objectives state that there will be increases in knowledge (approximately 10% to 15%) about sexually transmitted diseases **(STDs)** for both women and men in the project area. Again without a mid-term baseline study, it is difficult to accurately judge the level of increased knowledge about STDs in the project area.

In reviewing the STD project outputs, we observe that project personnel (assistant project manager, 2 educators and 4 CBD supervisors) were to be trained to provide promoter training and group education sessions about **STDs.** According to the project quarterly reports this training was completed for project personnel during year one.

In addition, by the end of the project 150 CBD volunteers are to be trained in STD/AIDS prevention. In other words, half of the total number of promoters to be trained by the project were to be trained in STD/AIDS prevention. So far 62 promoters have been trained.. 50 to 60 more are scheduled to be trained before the end of year 2. At present the project is trying to decide whether they need to train 300 promoters in order to maintain 100 active promoters. If they decide to train fewer promoters then they will proportionately reduce the number requiring STD/AIDS training. A decision is expected before the end of year 2.

Another output refers to a number of individuals informed about STDs through individualized counseling. Project records do not break out STD counseling rates but it appears that counseling occurs when someone comes to the clinic for STD services. According to the internal evaluation report produced by the project, all the STD cases reported by the CBD project have been diagnosed through pap smears (which means that they- are either trichomonas or monilia) and .there were a total of 211. In the internal evaluation report it is noted that 31 STD talks have been given but it does not indicate how many individual6 participated in the sessions.

The last output for increasing knowledge about **STDs** is the number **of** referrals to the CIES clinic. According to the internal evaluation document there were 211 referrals which is 34% of the amount of STD referral6 anticipated at this point in the project. So the project activity has not generated the number of referrals that was anticipated through its educational and promotional activity.

3. **Control of** Diarrhea1 Diseases

outputs:

The **CDD** component activities were.scheduled to begin during the first quarter of year two (October-December 1995) and were actually initiated in March 1996. The seven project staff have received initial and refresher training in the management and prevention of diarrhea1 diseases.

Specific outputs for IEC activities and case referrals were not quantified in the DIP. Each of the 202 IEC activities carried out to date have reached an average of about 30 women and men. Assuming them to be between 15 and 49 years old, the 12 education activities on CDD will have reached about 360 people, or 4% of the target population to date.

Expectations:

The project surmised that women seeking assistance from the CBD volunteers for episode6 of diarrhea in their children would or could be attracted to family planning services. Neither this assumption, nor the reverse that family planning users will demand ORS packets, can yet be proved but they do not appear to be the case. Interviews with CBD volunteer6 suggest that the two services **are** likely to stand on their own merits. 'In either case, it is too early to draw conclusions. The distribution of free ORS packets **through the** CBD system of volunteers, however, makes a lot of sense but will need considerable awareness building.

II. EFFECTIVENESS

A. FAMILY PLANNING

In general the project is making good progress in meeting its objectives for family planning. Although the project had a delayed start-up due to the decision to subcontract the bulk of the project to CIES, there has been significant progress during the past 9 months. **Also it is not** possible to completely measure advance6 in knowledge and practice in the beneficiary population until there has been another knowledge and practice survey, which will not occur until the end of project. But indirect indicator6 appear to show that good progress is being made.

As noted above although we do not have data from a second baseline study to completely measure practice, from CBD services statistics **it looks very** probable that the project will meet its primary objective of increasing the number of WRA using modern methods from 10.6% to 30%. Judging from the 'fact that the project seems to be on track with its IEC activities which are the outputs for the

knowledge objectives, one can infer that progress is being made in increasing knowledge in the beneficiary population. To date the amount of professional and volunteer training courses planned appear to be on track. Also the number of community education activities conducted so far coincide with project targets planned for IEC.

The major area where there is a discrepancy between planned yearly targets and actual accomplishments is in the area of contraceptive methods distributed. While progress is good. for the distribution of condoms, vaginal tablets and depoprovera (all of these are more than 100% of target achievement), it is behind in the acceptance . . and distribution of IUDs, pills and traditional methods. There appear to be several explanations for this. Until now both IUDs and pills require referrals to the clinic and although the promoters are supposed to be reimbursed for patients that they have referred, there has not been a good mechanism in place for keeping track of them. Also the amount that the promoter is reimbursed barely covers her transportation costs for bringing the patient in. The other thing that came out in discussion with the educators and promoters is that they are more comfortable educating people about condoms and vaginal tablets. The pill and IUD require that more information be given to the user about side effects, advantages and disadvantages and danger signs.

Suggestions: Some things that the project is considering or might want to consider to deal with this are:

* The targets set for pills and IUDs outlined in the DIP appear to be too high for this program. The assistant project director has adjusted the rates for specific methods and for couple years protection for years 2 and 3 of the project. She was able to justify this by noting that this is a pilot program and they did not have good data upon which to base their CBD projection rates for this project.

* The CIES director of services noted the importance of making pills more accessible to people in the project area. He stated that there is a demand for pills in El Alto pointing out that pills are selling in pharmacies. He suggested changing the medical norms that require that patients receive their first cycle of pills in the clinic. He said that with the low dose pills and the young women who use them, the complication rate was reduced and it wasn't necessary to see the patient before she started the pill. He Suggested that the patient get started with the promoter with a one or two month supply and then come in for a check up and a pap smear afterwards. Also if the promoter were able to sell the first cycle of pills and get patients started, then they might be more interested in promoting the pill. There was some concern on the part of project staff about varying from the SOH norms

which require an initial clinic visit for pill use but this alternative could be proposed as a research project in which pill complication and dropout rates could be measured and changes in protocol made later if necessary.

* Because of the hesitation on the part of the promoters to freely educate about use of the pill and IUD, it might-be useful to address these topics in regular follow-up education sessions with the promoters. The project tries to hold monthly meetings with the promoters, but the promoters are not always able to attend. It was felt that if the project would pay for transportation and offer lunch for the promoters (which they have the budget to do), then there might be better attendance. Given that one of the strategies of this project is to encourage promoter retention, it would be good to strengthen education and training opportunities such as these monthly meetings.

* Another barrier related to patient referral to the clinic was that there was not a good mechanism for crediting the referral back to the promoter and the incentive of 3 Bs per referral barely covered the transportation cost of bringing a patient into the clinic. There are several possible ways to improve this situation, such as giving the patient a referral form to take to the clinic with the promoter's identity on it so it can be noted. The IEC subcommittee developed referral forms for this purpose as part of the print materials package, which could be bought by the project if they do not have other forms. Project personnel noted that many times people lost or forgot to take medical forms when they came to the clinic. However if they were offered an incentive to bring the form, such as a discount, there might be better results. Another possibility is for the project to explore some better promoter incentive options with CIES. The project could also work with the promoters to develop referral strategies, such as bringing in the referrals in groups rather than one at a time.

B. SEXUALLY TRANSMITTED DISEASES

Without the repeat baseline study, it is difficult to judge exactly what the impact on knowledge about STDs has been in the project area. However in reviewing the process indicators (outputs) it is evident that they are making progress in STD training and educational activity.

The project staff were trained about STDs and AIDS during the first year of the project. During the second year two groups of promoters were trained (62) and two more are planned before the end of the project year (50). Although there was a delay in the planned STD training, they have'caught up and are planning to keep the rest of the training sessions as scheduled (unless they decide

to recruit fewer promoters). There have been 31 education talks given about STDs to community groups which represents about 61% of the activity that they had expected to conduct by now. Again the delayed training schedule may have affected the actual number of educational sessions that the project has been able to provide.

As mentioned above, there is not a specific target established for number6 of people to be counseled about STDs. Nor does the project keep track of STD counseling sessions. However counseling is given to patients who are referred for STD diagnosis or treatment and to date there have been 211 people referred.- This represents about 34% of the number of referrals anticipated by now. Judging by the low number of referrals, most of which have come from Pap smear diagnosis, it would appear that there is a need for more promotional, informational and educational activity related to STDs.

According to the preliminary reports from the ethnographic study, while there appears to be a fair amount of understanding about family planning and modern methods among the target population, there does not appear to be much understanding of what STDs are or how they are transmitted. There is also a tremendous amount of stigma attached to having an infection of the reproductive system and usually the woman is blamed for having the disease even if it was transmitted to her from her husband. While the study respondents often did not know what STDs were by name, they were familiar with "chancre" and rashes and sore6 of the genital area but they were embarrassed to talk about it. Given that the incidence of STDs is increasing in El Alto, according to Ministry of Health sources, it would seem very important for the project to stress education in this area. The tremendous sale of condoms in the project area indicate6 that there is concern not only about avoiding pregnancy but also for avoiding infections. This is backed up by interviews with project staff and promoter6 who stated that concern about contracting STDs were reported as one of the main reasons for the high demand for condoms.

suggestion: Given that STD education represents only 15% of project activity, and given what appears to be a tremendous amount of ignorance about STDs and how they are transmitted among the target population, it would be worth exploring alternative mechanisms for generating awareness about STDs. It appears that project staff have a limited amount of time to give educational talks about STDs. One such mechanism would be the use of ma66 media (radio and TV). Mass media is very good for generating awareness about a problem and once they are aware, directing them to services for treatment. When the evaluators discussed this option with project staff, they were open to it but Stated that they had limited technical ability and resources to fund this kind of activity. However, in discussions with PSI the evaluators learned that they are producing informational radio spot6 as well

as pamphlets and brochures about STDs and AIDS that they would be willing to make available for project use. PSI also stated that part of their agreement in working with CIES is to strengthen CIES's communications department, so they would be open to collaborating on communications activities with the CBD project.

C. CONTROL OF DIARRHEAL DISEASES

The target population for the CDD component is an estimated 10,949 children under two years of age. Assuming that on average each child suffers three episodes of diarrhea per year, there would be 32,847 cases of diarrhea per year in the project-area (covering three of El Alto's six Health Districts). In 1994, the Regional Secretariat of Health reported attending only 8,582 cases of diarrhea in children under five years in all of the 19 health facilities in the El Alto Region. Another 2,116 cases were attended by volunteer health promoters (RPS). The government services, including the RPS, likely saw only a fraction of all diarrhea1 cases.

If each of the 100 planned CBD volunteers successfully covers 30 families (a very optimistic assumption), then 3,000 families will have access to ORS packets and information on the management of diarrhea1 diseases. At 6 persons per family, and assuming that 6.48% of the Bolivian population is under two years (SOH estimates), then the CBD volunteers will attend about 1,200 children with 3,600 cases of diarrhea. If each episode requires three ORS packets, then the project's 3,700 packets supplied will cover only about 34% of the accessible need. The second primary objective for the CDD component proposes that 50% of children under two in the project area will be treated with ORT. This means that up to 50,000 packets may be demanded per year (an unknown number of cases will hopefully be treated with home solutions) for the estimated 16,500 cases. The above estimates also suggest that the proposed 100 CBD volunteers can likely be expected to cover only about 20% of the target population.

There are three major constraints the project faces inmeeting the need for the control of diarrhea1 diseases in the project area. First, 100 CBD volunteers are an insufficient number to adequately cover the estimated 29,000 households (an average of 290 per volunteer) with home visits, group education activities and access to ORS packets. In addition, the current distribution of CBD volunteers is *very* uneven (see Section 1V.D.). Second, the number of possible community education activities on CDD also would not appear to be sufficient to reach a significant portion of the target population given the time remaining in the project, particularly given the need for follow-up and reinforcement of messages from multiple sources. Third, the CDD component is not benefitting from *mass* media campaigns as is the family planning component.

III. RELEVANCE TO DEVELOPMENT

A. FAMILY PLANNING AND SEXUALLY TRANSMITTED DISEASES

As stated above, the CARE/CIES CBD Project is subcontracted to CIES and works out of the El Alto clinic offices. In addition to the CBD program, there are clinical services offered and an associated doctors program in which a CIES representative sells family planning methods to local doctors who also receive training from CIES. The CBD program does not work very much with the associated doctors program but it does refer to the CIES clinic for clinical methods *or* other health problems. It appears that services referrals to the clinic have not increased as much as was anticipated so recently there has been quite a bit of emphasis on increasing promotional visits by project staff.

CIES is the major family planning services provider in the project area. PROSALUD which also *receives* funding by USAID for primary health care also has clinics in the project area and does provide family planning as well as other services. The two institutions view each other as competitors so there is not a lot of collaboration between them. It was interesting to note that some of the promoters interviewed were also now or had been promoters for PROSALUD. These promoters stated that they referred to CIES for family planning and to PROSALUD for primary health, so at least in the minds of these promoters the areas of potential collaboration are clear.

The Dutch government also has a primary health care project which due to the redistricting decisions made by the government, has now expanded into the CARE/CIES project area. However, in this case, the Dutch program has made a strong effort to meet with and collaborate with CIES. In the past, the Dutch government has often funded CIES to conduct Pap smear campaigns and process the results in the CIES laboratory in El Alto. So there is a good basis for continuing collaboration.

CIES also regularly refers patients to Los Andes Hospital which is located close to the CIES clinic. The hospital has recently named a priest as its director and made a decision not to work with family planning, so CIES will have to find another referral source for these needs.

The Director of the El Alto CIES clinic meets regularly with a network of local NGOs to compare activities and look for coordination opportunities. The Gregoria Apaza and CIDEM offices are located close by and the organizations often coordinate with CIES in educational and promotional activities. At one time CIES provided training and education to women's groups associated with PROMUJER (a PL 480 funded women's credit program) but now PROMUJER has its own health program and has not asked CIES to participate.

The Director of the El Alto clinic also has regular meetings with the Director of the Regional Secretariat of Health (RSH) in El Alto in order to coordinate activities and information, such as receiving rehydration salts for CDD activities and other supplies when necessary. The director of the RSH El Alto is very interested in the project as it is in line with priorities established with the National Secretariat of Health (SOH) and with health priorities established for El Alto. CIES provides information to the national Health Information System and the RSH director suggested that CIES recruit the RSH Popular Health Representatives as CBD volunteers for the project.

Through the network of promoter6 and the educational activities that the project is encouraged to do, there is a strong collaboration with neighborhood organizations such as "Juntas Vecinales", mother6 clubs, work groups etc. It is anticipated that these relationships will grow as the project advances with its activities.

In sum, there are a lot of organizations working in development in El Alto but CIES seems to have found its niche as a major family planning care provider. The project is fitting in well in El Alto in this niche and is also helping CIES expand into other areas of activity such as STDs and CDD and is strengthening its presence in the area through promotional activities.

B. CONTROL OF DIARRHEAL DISEASES

There are at least 26 health facilities serving the 454,000 people (1994) living in El Alto, seven in the CARE-CIES project area. The Regional Secretariat of Health (RSH/SOH) operates 2 hospitals and 17 health centers, and PROSALUD, a private organization has another seven medical centers. In addition, churches and other NGOs may operate neighborhood health posts, and there are numerous private medical practitioners. Also, since a large portion of the population has recently immigrated from rural areas, it is very likely that there are traditional herbalist6 and healers practicing as well. The RSH and several NGOs have also trained community health workers (RPS) to provide basic primary health care outreach and referral services. These are the main providers of health services which treat, on demand, diarrhea1 diseases in children.

CIES has but one clinic in El Alto, and is primarily known for providing reproductive health and family planning services. In spite of the existence of these services, only a small percentage of people utilize them, largely because of cost and cultural constraints, particularly during the early stages of diarrhea and dehydration. There remains a large unmet need in the population for education to prevent and manage diarrhea episodes, and supplies (ORS packets) to prevent dehydration. Due to the number and distribution of the health facilities, it is advisable that CBD

volunteers and project staff refer cases of acute diarrhea and dehydration to the closest facility for treatment.

An important emerging issue for the CDD Component is the marketing of a commercial ORT product, Sal de la Vida. It is produced locally and is very similar to the USAID-provided ORS packets. This social marketing effort began in February and is supported by UNICEF. The social marketing has been minimum and tentative, compared to the massive family planning media campaigns. The purpose of the Sal de la Vida campaign is apparently to make ORS packets widely available and sustainable through commercial outlets. The proposed cost is reported to be Bs.1.00-1.80 per packet, or $US.0.60-1.08 for a S-packet treatment cycle. The situation is complicated because of the national health policy to provide free health services to women and children under five years, including treatment of diarrhea and pneumonia.

IV. DESIGN AND IMPLEMENTATION

A. PROJECT DESIGN

In the Detailed Implementation Plan (DIP), CARE proposed two major change6 from the original project proposal submitted to AID. First, the project area and target population was reduced; and second, the project was to be implemented through a sub-agreement to CIES, a national non-governmental organization (NGO). Both Change6 were approved by the AID/BHR/PVC.

1. Project Area and Taraet Population

The original project design proposed working in the total urban area of El Alto, a rapidly growing city of 454,000 inhabitants, (1994) situated on the Altiplano adjacent to La Paz and surrounding its international airport. After careful analysis of Staff resources and logistics considerations, and in consultation with the Regional Secretariat of Health of El Alto, the three parties (CARE, CIES and the RSH) agreed to concentrate project efforts in portions of two of the then three RSH Health Districts.' The total population of the new project area is 173,888; the new target population was reduced to: 44,537 women of reproductive age (WRA, 15-49 years) for the family planning component; 42,682 men 15-49 years plus the above WRA for the STD/AIDS component; and 10,949 children under 24 months (plus an estimated 11,580 newborns in years 2 and 3) for the control of diarrhea1 disease component. The total revised target population is 109,748.

'In 1996, the RSH of El Alto wae reetructured into eix Health Dietricts. The CARE-CIES project location now comprieee three complete Health Districts but ham not changed in area or population.

The DIP also proposed expanding project service6 to two rural communities near El Alto. No explanation was provided to justify this expansion, other than the fact that most of the El Alto population is rural in origin. There are a number of reasons why CARE/CIES should not expand to rural areas during the life of the current project. There are only 15 month6 remaining in the project and that is not enough time to select, plan, organize and implement activities and expect to have any significant impact. The program in El Alto was delayed in starting and a large portion of the urban population ha6 not yet been reached with promotional, educational and CBD volunteer services. In addition, El Alto continues to grow at more than 7% annually. Attending rural communities would take valuable staff time and resources (vehicle, materials, etc.) away from the urban program. Also, initiating a rural program would most likely require implementing a second, different strategy.

2. Imolementation Throuah Partners-

Within two months of the project start date, CARE made the strategic decision not to implement the field activities directly but rather to provide CIES with the financial and technical resources to carry out all field activities. Negotiations between the two organizations were well underway at the time the DIP was prepared and the substance of a sub-agreement was presented in that document. CARE would retain the position of project manager and overall accountability for the use of USAID and CARE resources and the achievement of project objectives. CIES would hire all other project staff and be responsible for all field operations.

Due to the inexperience of both organizations and lack of established procedure6 in structuring and developing Contractual relationships within the context of a broader project agreement, the actual sub-agreement was not signed until the 17th month of the project implementation. The details of the sub-agreement were worked out between CARE and CIES between January and June of 1995. During this period project staff were busy with the baseline study and in writing the DIP. CIES was also in the process of restructuring its organization, and CARE Bolivia was also receiving contradictory and confusing instructions from its headquarter6 in Atlanta and its international finance office in Manila. In August, the draft Sub-agreement was sent to Atlanta; the sub-agreement was approved by AID Washington in November; and the document was finally Signed by CARE Bolivia and CIES in February 1996.

As a result of this lengthy and at times confusing process, a number of project activities were delayed because fund6 and property (vehicle, computer) could not be transferred in a timely or efficient manner from CARE to CIES, and specific roles and responsibilities were not adequately defined. In spite of the delays and frustrations, it appears that the redesign/sub-agreement strategy will be well worth the effort in the long term: an

important local NGO will be strengthen and the prospects for sustainability will be enhanced.

B. MANAGEMENT AND USE OF DATA

1. Data for Decision Making

Quantitative data on knowledge and practices in family planning, STDs and diarrhea1 diseases was collected through the baseline survey. A repeat survey was planned for the mid-term evaluation but was not undertaken because the project interventions began late and little change was expected. Qualitative data on knowledge,. attitudes and practices in these areas has been collected through an ethnographic survey which has just been completed. This information has and will be used in the design of community education, CBD volunteer training, and mass media promotional activities.

CBD volunteers provide data on the number of contraceptive users, contraceptives sold, ORS packets distributed, and educational activities undertaken. Project supervisors and coordinators record data on the number, type and location of community education and promotion activities, family planning and STD counseling sessions in the clinic, and CBD volunteer recruitment, training and retention. The CIES clinic reports data on the movement of contraceptives, clinic services for family planning, STDs and diarrhea1 diseases patients, and financial movement.

At the community level, CBD supervisors review monthly user records with volunteers, taking the opportunity to identify and discuss problems, assure adequacy of supplies, and plan future activities. supervisors and coordinators consolidate monthly reports and as a group and individually use this information to track progress and identify problems, for follow-up of volunteers, planning community education and promotion activities, and determining contraceptive and ORS supply needs.

The deputy project manager reviews monthly reports for-consistency and completeness of information and for ordering supplies. The project manager prepares quarterly project implementation reports (PIR) which compare planned and achieved outputs. This information is analyzed with project staff to review progress and prepare plans. Project staff have undertaken two in-depth reviews of project data: in November 1995, at the end of the first project year to evaluate progress and re-program project activities; and again in May 1996, in a self-evaluation exercise, to prepare for and orient the mid-term evaluation.

2. Jiealth Information System

The project health information system is based on the information system designed by CIES for its CBD program nation-wide. The project manager and deputy project manager conducted a thorough review of this system, including a series of interviews and meetings with CIES personnel, particularly project staff. This analysis revealed data and paper flows, time spent, data use, and other important aspects of the existing system and led to ways to improve the system both for the child survival project and for CIES in general.

The project information System is managed by the deputy project manager. Information flows from the CBD volunteer6 to the supervisors and coordinators who consolidate and analyze the data and add their activity data, before passing it along to the director of the El Alto clinic. Promoter tracking and community promotional activity data are plotted on a large wall map and on individual zone maps. The clinic director sends monthly reports on the CBD program, clinic services and the associate doctors program to the director of services at CIES central office. The deputy project manager reviews and analyzes project data, consolidates this data with data from all CIES CBD programs, and passes project data on to the CARE project manager who prepares reports for CARE and USAID.

3. Lessons Learned

For both CIES and CARE, the child survival project in El Alto is an important learning experience in working in partnership and in urban CBD programming. Documentation is an important aspect of the project. CARE has produced two "lesson learned" reports one by the project manager in March 1996, and the other by the finance manager in May 1996. The former report addressed a number of issues faced by both organizations during project start up and implementation and identified other issue requiring further attention. The latter report primarily concerned the subagreement development process and relations with the CIES finance department. The CIES -staff also identified lessons learned on strengths and weaknesses of the project in their self-evaluation document.

CIES is using the lesson learned to improve and expand its CBD volunteer program throughout Bolivia. CARE Bolivia is eager to apply this experience to enhance programming in urban areas, in reproductive health and in working through partnerships. CARE headquarters is very interested in the contribution6 that this project will provide to furthering CARE's global strategy of increasing effective partnership relationships.

C. COMMUNITY EDUCATION AND SOCIAL PROMOTION

1. Information. Education. and Communication

Presently there is a quite a bit of activity in CBD service provision, promotional activity and community education. As noted above the level of service provision is good and increasing. Since the beginning of the project promoters have reached 8,882 new users (20% of the target population) and 9,001 continuing users. The promoters have made a total of 22,994 home visits in which they have informed people about family planning and sold contraceptive methods. In addition project staff have conducted promotional activities at 57 health fairs and during 54 promotional visits to project neighborhoods. Project staff have also conducted 202 educational talks to community groups in the project districts reaching 5,842 participants (999 of target). The talk6 and promotional activities usually include: promotion of CIES, educational information about family planning and use of contraceptive methods, information about sexually transmitted disease6 and AIDS, and most recently information about Control of' Diarrhea1 Disease in children under 2.

In general the educational activities are organized through formal neighborhood groups (Juntas vecinales, mother6 groups etc.) and through health fairs. For health fairs staff work with community members who are contraceptive users or have participated in education sessions in order to give them the opportunity to develop educational activities. During the evaluation, the evaluators noted that in addition to working with organized neighborhood groups, project staff also conducted education with informal groups, such as road gangs that were repairing the roads in the neighborhoods. They often were creative in using their time. For example, if they went to a neighborhood to give a talk and the group was not meeting at the time, they would search around until they found a neighborhood group that was meeting, or they'd look for a street repair group, deliver their educational messages and then return to see if the original group was ready.

It has only been during the last quarter that there has been much activity in CDD education at the community level, since promoter6 were recently trained for this in March. Also during the quarter several sessions were delivered to the police regimens in El Alto, thus increasing the numbers of men educated through educational activity.

2. Materials Development

The CIES training department provides all staff training and oversees volunteer training programs. The training department has developed uniform messages about family planning and STDs through its work with the National training subcommittee and the IEC

subcommittee. Message content was developed and agreed upon when training and educational materials were developed by these subcommittees. These material6 were all field tested by the participating agencies and final decisions were made by the subcommittee work groups after reviewing the results of the field testing. Many of the training material6 used for the CBD project are the ones developed by the subcommittees as the CIES director of training and education has been active in these committees for a number of years. The CIES training and education department ha6 created educational module6 for all the educational activities to be conducted by project staff. These modules basically provide objectives, content outlines and evaluation criteria for each of the three areas of the project: family planning, STD/AIDs and CDD. These modules are not curriculum guides, and the project staff are expected to develop their own curriculum guides for teaching promoter6 and community members.

There were very limited educational material6 available during the community education sessions. The project staff had flip charts and demonstration tools to demonstrate how to use contraceptive methods for family planning and to protect against STDs and AIDS. They also had tools for demonstrating correct preparation of oral rehydration salts. However, there were no educational materials available to hand out to community members. According to most community education philosophies, it is very important for people to leave with some printed material about the subject discussed. Thus they can think it over, refer to it if they have questions and if they don't read, someone in their household probably does. When the national reproductive health materials were field tested in Bolivia, they found that on average 8 to 10 people read each educational material that was taken into the home. The reproductive health brochures, flyers, referral forms etc. that were developed for peri-urban audiences and field tested by the National IEC Subcommittee can be purchased by the project at a reduced rate through the John6 Hopkins University Population Communication6 Services program in La Paz. Since there are fund6 available in the project budget, we would recommend that the project buy them as soon as possible. CIES has also developed educational materials that could be used in the project. The STD/AIDS program at CIES also has materials which might be suitable for the project and would be worth reviewing. Given the large amount of materials that have been developed in the country and the need to use materials now, the evaluators would recommend that the project look for materials that have already been field tested and meet their needs rather than try to develop new ones.

3. Approach to Community Education

The evaluators observed community education sessions that dealt with family planning, STDs and CDD and were taught by team6 of project staff (supervisor6 and coordinators). The staff were

lively, spoke clearly, were often entertaining and provided demonstrations of their topics (i.e. how to put on a condom, how to prepare ORS solutions, pictures of what STDs look like).

Although the sessions were well taught, we do have some suggestions for improvement:

* Given the educational level of the audience it is important to really limit the amount of information transmitted per session and to follow up with printed material that can be referred to later. It is recommended that the educators try to limit their talk6 to 5 or 6 key messages that can be repeated and discussed during the session. This is particularly important during the informal street meetings where the participants don't have a lot of time to participate in the session.

* The information taught to the project staff by the CIES education department need6 to be brought down significantly to the level of the community audience. The sessions observed, particularly on STDs were much too complicated for the audience. i.e. The community did not need to know the three stages of syphilis or all the forms of gonorrhea. They needed to know three things: If they had any genital rashes, sores or painful urination, they should get it treated by a doctor, even if it went away. Their partners needed to be treated also. These diseases could affect their children if they are pregnant at the time. CARE has offered to send a consultant to work with CIES in the education area. It might be useful for her to work with the CIES education director in developing material6 or guideline6 for community education.

* The sessions observed could have included more audience participation. While the staff were entertaining in what they did, they could have involved participants in the actual demonstrations and encouraged more discussion during the sessions. These techniques keep the audience from becoming bored or distracted. It might also be useful to use more than one flip chart as the groups tended to be spread out and not everyone could see.

* In her review of the project, Jane Lyon6 suggested that project staff receive training in the Capacitando Sin Letras curriculum developed for illiterate audience6 in Guatemala. This has not occurred yet but project staff think its a good idea and the CIES education director and one of the supervisors have been trained to teach this course. The course provides techniques for encouraging audience participation and assessing their learning capacity. However, there was a concern raised that even if project staff were taught how to implement these techniques, they might not do it in practice. So field supervision by a trained participatory

educator is very important especially during the next few months until the staff is comfortable with the new methodology.

* While in general the sessions were well presented and accurate, there were some technical errors. The evaluators observed thateducationalmessages for hormonal methods (pills and depoprovera) were either incomplete or inaccurate. The March 1996 quarterly report note6 the same concern. As a result of this observation the project is planning to standardize and document key educational messages that need to be used in community education. It would also be useful to review technical content with staff and promoters on a regular basis. Perhaps this could be done at the monthly meetings. It was also mentioned in the reports that there are some technical areas that the medical staff either doesn't agree on or have given mixed messages about (such as exactly when to insert an IUD, start the pill or receive a depoprovera injection) and it is important to clear this up.

To date learning levels from training sessions with community promoters are assessed through pre and post tests. Evaluation of the community sessions is less formal. Sometime6 if it is an organized group, they ask the audience to pick questions from a box and answer them at the end of a session as a kind of post test. This is a useful method if they have the material and time to do it. As a suggestion, it might be useful to routinely ask two or three questions-at the end of every session in order to evaluate the impact that they are having on their audience. Given current concerns by the CIES education director about determining current levels of knowledge among the community participants, she could randomly attend education sessions being given by the project and ask a limited number of comprehension questions in order to get a general reading as to quality and effectiveness of the education interventions.

D. HUMAN RESOURCES FOR CHILD SURVIVAL

1. Project Personnel

The project DIP indicates that 100 CBD volunteers will be trained and active at the end of the project. Project record6 indicate that there were 88 active volunteers' in April 1996. On average, this means one CBD volunteer for about 990 women and men, 15-49 year6 of age, in the project area. (Table 1 in Annex E presents the distribution of volunteers and retention rates in each project area.) Not Only is this ratio of volunteer6 to target population

[2] The definition of an "active" volunteer ie any volunteer had turned in a report within the previoue three monthe.

high, but the geographic distribution is uneven. Figure 1 graphically shows that while six neighborhoods have reasonable CBD to population ratios (less than 1:600), 14 neighborhoods have either no volunteers or very high ratios (more than 1:1200). The clear conclusion is that the project needs more CBD volunteer6 and that they need to be more strategically distributed among the population. (Training and retaining 150 active volunteers, for example, would provide an average ratio of 1:580.)

To recruit, train and support the CBD volunteer network, CIES directly employs four (4) CBD supervisors, two (2) coordinators (in the DIP they are named "educators") who supervise the supervisors, and the person responsible for the CBD program at the national level. The national CBD overseer spends 902-952 of her time on matters related to the child survival project and officially is the deputy project manager. The child survival project manager is the only CARE employee on the project. The budget allows for a project secretary but this position has not been needed so far.

Several issues relating to the adequacy of the staffing pattern and the distribution and organization of work loads are described below in detail in section G, "Supervision." Briefly, the evaluators found that while the field team appear6 to work well together, the supervisors are overloaded, there is little justification for having two coordinators, there is a lack of leadership and systematic planning at the field level, and that the supervisors inefficiently have CBD volunteers randomly throughout the entire project area rather than each one concentrating on contiguous and discrete geographical areas thereby saving time and money (for transportation).

Given a need to increase the total number and improve the equitable distribution of CBD volunteers (see following section) there appears to be a corresponding need to increase the number' of CBD supervisors to five (5). Other suggestions for increasing the capacity of the staff in meeting target output6 and objectives restructuring the work load of the supervisors and hiring a driver for the vehicle which CARE donated to CIES for the project.

Another area of concern is that neither the CARE project manager nor the CIES deputy project manager have had sufficient experience or adequate training in financial management and budget control. This issue is discussed in more detail in section M "Budget Management" below. As a result they have not been sufficiently involved in this aspect of project management. Both organizations have agreed that additional training is needed.

2. Community Volunteers

Community volunteers are the most important part of the CBD program. Their roles are to promote and distribute condoms,

vaginal tablets, and ORS packets. (CIES and CARE should study the possibility of having volunteer6 also distribute pills, possibly as an operations research study to determine advantage6 and disadvantages.) In addition, volunteers provide information on other methods of contraception (IUDs, pills, injectables, etc.) which are available at the CIES clinic, as well as on the detection and referrals for STDs, cervical cancer, and diarrhea/dehydration.

CBD volunteer6 appear to be motivated and active, some with community groups, others through home visits and small informal group discussions at home or on the street. Income is a primary concern in these poor neighborhoods, but money does-not seem to be the primary incentive for volunteering. Rather, volunteers point to learning and service as their main motivation. Specific incentive6 include a small profit margin on sales of contraceptives, free medical attention at the CIES clinic for the volunteers and their immediate families (not including medicine6 or deliveries), training and education materials, and supervision. During the evaluation, observations and interviews indicated good rapport and positive interaction and feedback between volunteers and supervisors.

As of April 1996, project staff had recruited 243 CBD volunteer6 in the project area, of which 88 were active in April. Low retention rates in the three districts (31.7% - 39.8%) should be of concern. They represent a cost in terms of staff time for recruitment and initial training. The main causes of drop out are not fully understood, but likely include occupation with making an income, unclear criteria for selection, and inadequate follow-up by supervisors (currently they have too many tasks and don't have the time to provide adequate follow-up). One strategy to increase the number of active volunteer6 as well as to increase the retention rate would be to re-visit inactive volunteers in order to: I) understand why they became inactive (define better criteria of selection and means of support), and 2) to encourage them to become active again.

Supervisors note that they often do not find the CBD vofunteers at home when they (the supervisors) make their rounds of support. Two suggestions for rectifying this are: 1) schedule regular visits so that the volunteers know in advance the time -and date their supervisor will visit each month, then keep to the schedule; and 2) hold regular monthly meetings with all the volunteers in a specific geographic area each month. This is *more* efficient in terms of collecting monthly reports, re-supplying contraceptives, ORS and informational materials, and providing in-service training. These meetings also have the added incentive of creating a mutual support network among the volunteers.

3. **Training** Content and Methodoloav

In general all project **field staff** have received five basic courses. These are basic family planning, Family Planning Counseling and interpersonal communication, active participation educational techniques, STD/AIDS, and basic CDD. The staff have also received an annual refresher course. All courses last between 2 to 5 days. Course content, schedules and modules are available in annex H. Staff training was performed as scheduled with the only **change** being that specific course contents were distributed differently among the courses than as described in the DIP.

It is clear that the course contents are very appropriate for the program. They deal with the three subject areas to be addressed and they include skills training **for** effectiveness in the provision of individual counseling and for group teaching. Pre and post tests revealed that staff retained a high comprehension level of the training received (averaging about 802). In order to reinforce the training skills, follow-up activities were performed on a regular basis during project meetings. These included exercises to reinforce knowledge and practice giving educational presentations among staff in order to reinforce use of active participatory techniques. The CARE Reproductive Health Director commented that the project staff's educational abilities have really improved over the project period.

All of the staff training occurred as it was originally planned in the DIP. However, training for CBD volunteers was delayed due to a number of reasons:

* It was more difficult to recruit CBD volunteer6 than originally anticipated, so they did not have enough (100) for four courses by August of 1995.

* August was not a good time to provide training because many residents of El Alto travel during that time to festivals in different areas of the country.

* The staff did not clearly understand that they had to recruit promoters from inside the project areas. As a result many of the trainees from the first course did not work in the project area and did not continue with the project.

As a result of this delay, most of the CBD worker training did not occur until the second year of the project. During the second year most of the scheduled training has been completed or will be by the end of the year. 7 out of 8 basic courses have been provided to approximately 183 new promoters that have been recruited during the year. Two CDD courses have been proved to old promoters and two more courses are planned before the end of the year. Two STD/AIDS courses have been held for old promoters and two more courses are

scheduled this year.

So far, recruitment has been good and participation has been enthusiastic with fair knowledge retention levels evidenced in the pre and post tests from the courses. The staff educator6 follow the same training course outline as they are given in the training they receive from CIES. However, they are talking about simplifying the counseling and interpersonal communications course for the promoters and only giving them the interpersonal communications part. As noted in the community education section of this report, it appears that course material really needs to be made understandable for community volunteers. It would also be useful to have regular follow-up training refresher courses for the volunteers. This could be provided at the monthly meetings with promoters. The promoters interviewed by the evaluator6 commented that they would like more educational materials both for their own education and for distribution. The CIES education director stated that she would like the CARE education consultant to help with the development of more training manual6 for the promoters. Right now they only have the family planning manual developed by the training subcommittee. She would like to add STDs and CDD.

Suggestions: After having observed part of one of the basic family planning courses for promoters, a suggestion is that the staff include a section on how to sell contraceptive method6 in the community. Role playing involving how to interest potential clients in family planning, and how to deal with myth6 and rumors could be helpful to them. In addition it might be useful to teach them certain sales techniques and to give them practice role playing for their new promoter job. It might also be useful to give some of the more ambitious recruits some training in marketing and sales, helping them to take advantage of good opportunities in the El Alto area. Possibly PSI would be willing to collaborate with this type of training as they have active promoter6 distributing their products.

E. SUPPLIES AND MATERIALS FOR LOCAL STAFF

1. Contraceptives, STD Tests, and ORS Packet6

All contraceptives used in the project are obtained through the USAID-sponsored Family Planning Logistics Management (FPLM) program managed by John Snow, Inc. Supplies are requested two times per year from the JSI representative based on field projections. When supplies arrive in La Paz they are received and then distributed to operational agencies (including CIES and PROSALUD) by a local NGO named FAMES. The child survival deputy project manager make6 quarterly projections and requests for the El Alto program as well as the other regional offices of CIES.

At the El Alto clinic, distribution is handled by the secretary/

petty cash clerk. All family planning supplies used at the clinic are controlled by the staff nurse; the distribution of condoms and vaginal tablets used in the CBD volunteer program are controlled by one of the project coordinators. At each stage of transaction -- FAMES-CIES, CIES-El Alto, EL Alto-CBD volunteers-- there is a minimal price mark up to cover CIES management costs and, at the end, to provide the CBD volunteers with a slight profit on their sales to users.

During the past year, CIES, and others, have not received all the supplies they have ordered. There has been concern, by USAID and JSI, for lack of adequate control at the periphery, i.e. that supplies are ending up at commercial outlets like pharmacies rather than directly from NGO clinics and CBD volunteer6 directly to users. While this concern is warranted, and shared by CIES, it also has meant some limitation in meeting demand6 in the field.

Regarding the supply of condoms, USAID/Bolivia and the SOH are support two sources: no-logo (generic) condom6 supplied through the JSI/FPLM program, and a massive social marketing campaign for Pantera condoms managed by Population Services International (PSI). Pantera condoms are available through commercial outlets in the major cities of Bolivia including El Alto. Recently, due to the shortage of no-logo condoms from FPLM, Panteras were substituted. In fact, the strategy is to eventually replace the no-logos with Panteras in all public FP program6 as well as in the commercial outlets. The disadvantage of this strategy is that Panteras cost two and a half times more than the no-logos, and even though the CBD volunteers make a slightly hired profit they are encountering some resistance among users. CIES Will have to assess the impact of this strategy in terms of users once the no-logos are no longer available.

Supplies for the testing and treatment of STDs are purchased and managed only at the CIES clinic in El Alto. These supplies are purchased from various commercial supplier6 in La Paz. The CIES laboratory has not only become financially self-sustaining but has become a primary source of income for clinic operation in general. Overall, income for services rendered at the clinic now cover all but personnel costs, most of which are covered from grants.

ORS packets are obtained from the Regional Secretariat of Health (RSOH) in El Alto. The SOH currently receives donations of ORS from USAID and the packet6 carry the USAID logo. It is SOH policy not to charge for ORS packets (or other MCH services) and CIES is bound to follow this practice in the CDD program. Thus, neither CIES nor the CBD volunteers receive any financial incentive to *@market@* ORS packets.

Similar to the supply of condoms, in February 1996 UNICEF, et al., initiated a social marketing campaign for a commercial brand of ORS

salts, Sal de la Vida, which is being produced and marketed by a local pharmaceutical company. This campaign is so far very low key and has had little effect. It is also unclear how much support will be afforded to this effort, given the SOH policy of providing free ORS packets. One unresolved issue is whether USAID will continue to provide the SOH with ORS or if the SOH will have to purchase ORS from other suppliers in order to maintain its policy.

2. Trainina and Educational Materials and Euuioment

The purchase of training, educational and promotional materials was delayed and prolonged due to the delay in approving the subagreement and the inefficiency of the interim disbursement procedures (see section M.2 below). The original budget contained money for three motorcycles. Given that none of the supervisors know how to drive and that public transportation and the project vehicle are available, these funds were reportedly re-programmed to enable the purchase of a TV/VCP and other educational equipment for the clinic. As of April 1996, CARE had overspent its procurement budget by $15,132; all further purchases of supplies, materials and equipment for project activities will have to be made by **CIES** from subagreement funds. The evaluators recommend that additional materials are needed for promotional and educational activities. These are described in section C above.

F. QUALITY ASSURANCE

As noted in **the** above section on education, the project manager, **assistant** manager and the CARE Reproductive Health Sector Manager have periodically visited the project while they are conducting educational sessions. They have given feedback to project staff regarding inaccurate information and made recommendations as to how to correct it. In addition, weekly staff meetings are held with the assistant project director where issues of specific skills and knowledge needed to meet project objectives in a quality manner are addressed. Project staff have also made an effort to be updated on what is going on with reproductive health in Bolivia **by** attending workshops and meetings held by agencies working in the field. For example Project staff have regularly attended both the National Services Subcommittee and Logistics Subcommittee meetings as well as the annual assembly meeting of all subcommittees. They also attended Procosi meetings, the abortion workshop sponsored by the committee for reproductive health rights, and various workshops sponsored by Mothercare, the son, ILPES, PSI, Georgetown University, and **CARE**.

A related activity is a quality of service review that was conducted by CIES in El alto with assistance from IPPF during the beginning of the second year of the project. Interviews with clients who had just received services from the clinic were conducted. Questions asked included how they felt about the

services, how convenient the clinic hours were and the price of services. Clinic staff were also interviewed concerning their impressions of client satisfaction. After 25 interviews are completed, the information is analyzed through a feedback system that specifies the problem detected, corrective action taken, person responsible for the action and time for correction.

The project also contributes to quality assurance through the rotating presence of either one coordinator or one supervisor who provide counseling and patient orientation in the clinic. This is done so that they can promote quality treatment in the clinic for patients, especially those referred through the CBD program.

A related factor impacting quality is that the coordinators and supervisors who act as clinic counselors speak Aymara and Quechua. This way they assure that women who do not speak much Spanish can be well attended in the clinic. They can also communicate effectively during the education sessions conducted in the field.

Other considerations impacting quality that the project has taken into account are its interest in educating men and recruiting male promoters (a rough estimate indicates that about one third of promoters are men). The project has been particularly active during the last two quarters in educating men, particularly police in the El Alto region. The police are very interested in reproductive health education and services as they are concerned about STD transmission.

G. SUPERVISION AND MONITORING

As noted in the first annual report, one of the initial contributions that the project made in strengthening the supervision system was the development of a personnel management system. Early in the project, CARE and CIES developed clear job descriptions for the positions of coordinator, supervisor and CBD volunteer. Staff responded positively to this stating that the position descriptions clarified their roles and responsibilities vis a vis the project. The assistant program manager then developed a personnel performance evaluation system (based on CARE's system). As a result of this system the project was able to identify certain problems with supervision that they were encountering and has made attempts to correct them. For example one of the coordinators was not fulfilling the leadership role that was expected. This was brought to her attention and with support from the project manager and assistant manager, she was able to improve. In another situation, a supervisor was found to have weak planning skills which were strengthened by her supervisor's attention to this matter.

The two most recent quarterly reports document the supervision needs that the project has identified and what they have been able

to do to resolve them. During the initial phases of the project the assistant project manager was not able to provide supervision to project staff due to competing demands from CIES to pay attention to other CBD projects that she was managing. Once aware of the problem the CARE project director with help from the CARE Director were able to convince CIES to allow the assistant manager more time to supervise the project. The quarterly report states that after this the assistant manager was able to work with staff and make them more aware of how to work more effectively in the community. As a result volunteer recruitment improved, as did clinic referrals. The project manager notes that continuing communication with and close supervision of field --staff is very important especially during this second year of the project in order to ensure that community activities are implemented in accord with project objectives.

While observing and interviewing project personnel the evaluators noted that the supervisors seemed satisfied with their supervision by the coordinators. Supervisors and coordinators usually work together as a team. The coordinators accompany supervisors to the field where they engage in promoter visits, educational talks and promotional visits. In fact there seemed to be little difference in their capabilities. Although there was a difference in their responsibilities, the supervisors were expected to take complete responsibility for supervision and distribution of methods to the CBD promoters. The supervisors would also work jointly with the coordinators in the provision of educational talks and promotional visits. The coordinators were expected to take the lead in conducting educational activities but that was not observed by the evaluators. The supervisors really preferred being involved in educational activities. The supervisors also noted that their supervision of CBD volunteers were very demanding. They each supervise between 25 and 35 promoters and often are not able to reach them all twice a month as is planned.

Numerous guidelines and supervision forms have been developed by the training and education department to be used by project personnel. Personnel have been trained in the use of some of these during the courses given to them in year one and will be trained further in the use of new forms developed as a result of the self evaluation workshop held in May.

There are guidelines for:

* counseling
* how to prepare health fairs
* what to ask during home visits (for promoters)
* what to ask when contacting organizations
* projecting videos to community audiences

There are supervision forms for:

* promotional visits (to be used by coordinators)
* educational talks (to be used by supervisors and coordinators)
* supervising counseling sessions
* supervising the organization of a health fair
* evaluating the work of a promoter (new form - will train supervisors to use the form)
* evaluating the knowledge of the promoter (new form for supervisor to use when working with volunteers).

The coordinators receive supervision from the assistant project manager on a monthly basis when they have project meetings. Or if she decides to make supervisory visits to the field but these are not planned visits and tend to be spontaneous. There was a little confusion voiced by the coordinators regarding who their supervisors really were. While there was recognition that the assistant project manager's supervision had been helpful in terms of orienting their work in accord with the project goals, there was also a feeling that everyone was checking up on them. They stated that they were being supervised not only by the assistant project manager but also by the project manager, the clinic director, the CIES training director and the CARE Reproductive Health Sector Manager.

Conclusions and suggestions:

There appear to be some basic concerns that have surfaced regarding program structure. It seems that there is not much difference between the abilities of the coordinators and the supervisors. There is also a strong commitment to doing the work together as a team. As a result, there is a lack of leadership in the team. The supervisors are overloaded with their promoter responsibilities and the coordinators could probably be doing more work. As it is they each spend 20% of their time doing counseling in the clinic which is not a project activity. The obvious solution would be to make one coordinator a supervisor. Four supervisors don't need two coordinators. However, there is still a leadership problem and neither of the coordinators appear to have the advanced skills needed to orient, develop and lead the team in family planning, STD and CDD field activities. The assistant project manager really does not have the time or the educational skills to really develop the field abilities of the supervisors and coordinators. The evaluators have discussed this problem with the project manager and she is interested in exploring a solution with CIES. CIES management is also aware of the situation and is willing to make changes. The evaluation team would recommend that the project manager and CIES review these observations, take a look at the program budget and explore options to improve the situation within the CIES structure.

There are also some structural issues that need to be resolved in terms of the supervisors' workloads. In keeping with the "equality" of the team, instead of delineating geographical areas for each of the supervisors to work in, they decided that each of them should work in all project areas. Decisions regarding who supervises which promoter are made randomly by the team. While this is an egalitarian way to divide up workloads and may have worked as long as each supervisor supervised a small number of volunteers, it is no longer practical at this stage of project development. The result is that the supervisors who already do not have enough time to complete their work, have to transport themselves over the two project districts trying to supervise their promoters and complete their reporting and distribution tasks. It would probably be more advantageous to work in delineated geographical areas. There would be less time and money spent in travel, they would become better known and get to know people in their respective zones and also become aware of meetings and activities going on in them.

Another structural issue has to do with the cost of transportation that the supervisors and coordinators are expected to bear. CIES does not reimburse separately for transportation. Staff are expected to pay transportation costs out of their monthly salaries (no matter how much travel they have). Given how low salaries are, one can understand why staff does not want to run all over the project areas to conduct their tasks. The project budget has funds for transportation expenses and the assistant project manager recently got permission from CIES to reimburse transportation costs, if the staff submit travel forms for this. However when this was reported to the staff by the evaluators, they responded that they did not have time to fill out more forms. There is also a project vehicle that could be used for project activities but there is no driver. (The coordinators and supervisors do not drive). There is also money in the budget for three motorcycles and CARE is willing to train staff to drive them. So the evaluation team recommends that the project directors get together with CIES, review the budget and try to work out a solution for these transportation problems, In order for this program to be effective, staff need to be traveling around the field area on a regular basis.

Another suggestion is that the project provide supervision training for project staff. It would appear that some of the supervision being provided is very control and performance evaluation oriented, without enough attention being paid to counseling/support, group problem solving and on the job education. As pointed out in the project quarterly reports, staff still need a lot of education and support in order to conduct their tasks efficiently.

H. REGIONAL AND HEADQUARTERS SUPPORT

1. Administrative Monitoring

The primary responsibility for monitoring administrative matters related to CARE projects rests with the country office. Each project and project manager is directly supervised by a sector coordinator or the assistant country director for program. The supervisor closely monitors the quarterly project implementation reports (PIR) prepared by the project manager and, periodically the project's financial reports which are prepared by the local finance office and CARE's international finance office in Manila. Each country office has administration and finance support offices.

The headquarters portion of the child survival project and budget is managed and monitored in Atlanta. Headquarters staff reviewed and, after considerable delay and confusion, approved the CIES subagreement. Headquarters also handles contacts with USAID in Washington and with the Johns Hopkins University, Child Survival Support Program in Baltimore, often following up on requests in both directions between the field and these offices. CARE headquarters, for lack of time, rarely provides feedback of project PIRs, in any sector.

2. Technical Support

Most of the technical support to the child survival project to date has come from the CARE Bolivia reproductive health sector coordinator who has an extensive resource library, experience and contacts. CARE's regional technical advisor6 (RTA) for primary health care (PHC) and population/family planning (POP), who are based in Guatemala, have only recently provided direct technical support to the project (see section I below). As of July 1996, these two technical units of CARE will be merged to provide better coordination and support functions.

Headquarters child survival support staff provided valuable and much appreciated assistance in the review and finalization of the project proposal and the DIP, by phone and e-mail, and located certain annexes for the DIP. Headquarters staff, neither of whom speaks Spanish, made no field visits to Bolivia during the first two project years. On site support will become the responsibility of the two RTAs, who will begin providing more regular and frequent technical backstopping to all four child survival projects in the Latin America region as of July.

I. PVO's USE OF TECHNICAL SUPPORT

1. Technical Assistance to Date

The following external technical assistance was provided to the

project during the first 21 months of implementation:

December 1994: **Marcelo** Castrillo, JHU/CSSP, 3 days for designing the baseline survey questionnaire and sample design.

October 1995: Jayne Lyons, CARE **RTA/POP/LAC,** 3 days for reviewing the STD/AIDS component and the CBD volunteer activity.

October 1995 - June 1996: Maria Dolores Castro and Juana Huanca, independent anthropologists, 5 months to design and conduct ethnographic research on traditional RAP in FP, STDs and diarrhea1 diseases.

June 1996: Miryam Wolfenson, 7 days for planning and logistics for the mid-term evaluation; Sandra Wilcox, independent consultant, 23 days as team leader of the MTE; and Jim Becht, CARE **RTA/PHC/LAC,** 20 days as team member for the mid-term **evaluation.**

2. Technical **Support** Needs

The following chart describes the current **technical support needs** which were identified by **the evaluators** and **project staff:**

TARGET GROUP	ASSIGNMENT
All project staff and supervising personnel	**Develop and conduct training in methods and techniques of constructive supervision.**
CIES Education and Training Department	**Develop field guide for community education and CBD reference manual for FP, STDs and CDD components.**
CIES Education and Training Department	**Development of** messages and **spots** for mass media campaigns on **STDs, CDD/ORT, and CIES.**
CIES Finance Department	**Programming Tech-Apro system to produce reports in CARE format.**

There ***are*** no particular constraints foreseen in securing or utilizing this technical assistance, other than identifying the right persons for the tasks. The project should be able to obtain most, if not all, of the TA in Bolivia.

J. ASSESSMENT OF COUNTERPART RELATIONSHIPS

1. Workina in Partnershin

The CARE-CIES partnership arrangement is a new and promising undertaking for both organizations. CARE has a global policy

directed at enhancing and expanding its work through partnerships with other organizations. CIES welcomed CARE's technical and managerial support as more than just another distant donor agency. This working arrangement was proposed as a means to increase efficiency, take advantage of each organizations strengths, transfer proven technologies and practices between the two organizations, and maximize the prospects for sustaining project benefits and strategies beyond the life of the project. The indirect benefits of the partnership were that CIES would become a stronger, more viable organization and CARE would gain valuable experience working in urban areas, in reproductive health, and in learning the advantages and disadvantages of implementing projects through partnerships.

At the time of this mid-term evaluation, a viable and effective working relation seems to have been established between CARE and CIES. The process of arriving at this point, however, involved delays, frustrations and a lot of negotiation. The major issues centered on the internal interests and autonomy of the two organizations, and meeting CARE's contractual obligations with AID. Particular stress was caused by the delays in finalizing the sub-agreement and subsequent transfer of funds to CIES for program operation, CARE's financial reporting requirements, and the definition of roles, responsibilities and lines of authority .and communication between CARE and CIES. These difficulties appear to be resolved, for the most part, and project staff in both institutions are working hard to recuperate lost time.

The most difficult part of implementing this project through a subagreement arrangement is that CARE's project manager (the only cARE staff person) is responsible and accountable to CARE for all project resources and results, but she has no direct authority over CIES's project staff nor its management of resources. While the CARE project manager has a legitimate role of overseeing, monitoring and contributing to project implementation, CIES personnel are accountable within their own organizational structure and operating practices. CARE's influence resides in the precision and clarity of the subagreement, mutually agreed upon annual and quarterly operational plans, clarity and respect for roles and responsibilities, and ultimately on the strength of human relations, good will, and mutual respect of the individuals involved.

2. Manaaerial and Technical Capacity

Project Management:

Both institutions have considerable experience in implementing health projects and in managing finances and program agreements from diverse donors. CIES was incorporated in 1987 and has been registered with USAID as a bonafide national NGO, authorized to

receive U.S. Government funds, since 1992. Both organizations have viable and experienced administrative, financial and program departments. The organizational structures are found in Annex G.

CIES staff have considerable technical experience in family planning and reproductive health. *CIES* provides these services through nine regional centers in the major cities of Bolivia. The central office has approximately 25 technical and administrative support staff. CIES field staff are **experienced** and motivated in working with volunteers and community groups. From observations of community education and volunteer training **activities,** the evaluators identified several areas of incorrect information being given and areas where training and educational methodologies could **be** improved but these were not serious deficiencies.

However, there are two areas of project management which deserve immediate attention. The first is the inadequate financial management capabilities of both the **CARE** project manager and the CIES deputy project manager (see section J.3 below). The second concerns the inadequate structure, leadership and operational planning capabilities of the field coordinators and supervisors team in El Alto (see section G above).

Institutional Strengthening:

The DIP states that as a result of this project **"CIES** as an institution will be strengthened through improved monitoring, evaluation and supervision systems for the CBD program." (pg.23) The CARE-CIES sub-agreement (Annex 2 - Program Description) goes further in stipulating that CARE will strengthen CIES by improving the information and supervision systems, training project staff in **the** development of the information and supervision systems, training staff in documenting (CBD) activities, and providing technical assistance **to improve** financial management and reporting. In practice, the institutional strengthening has gone both ways, with CARE learning a great deal about working in partnership and about urban programming.

Significant progress has been achieved in developing the project information system (see section 1V.B above) and financial management capabilities (see section 1V.M below). Little progress has been made to date on improving **CIES's** supervisory system for CBD activities. In addition, it is evident to the evaluators that CIES has been strengthened by virtue of this project in a number ***of*** **other planned** and unplanned ways. Most significantly, this project is providing an experience base to consolidate the CBD program nation-wide. The child survival project has also exposed CIES to linking a diarrhea1 disease control component with family planning and reproductive health activities.

Other examples of where CARE ha6 contributed to the institutional

strengthening of CIES include: articulating and systematizing procedures and practices; improving the personnel management system (developing job descriptions, redefining the pay scale, developing a personnel performance evaluation system): the organizational structure regarding the CBD program; proposal development for PROCOSI financing; quantitative techniques for baseline survey and evaluation studies; providing models and training for detailed implementation planning (DIP), monthly and annual operational planning. CIES had already been working on many of these areas; the child survival project has provided an added boost and resources to test and consolidate viable models.

3. CARE - CIES Communication and Coordination

communication between CARE and CIES generally take place at three levels: between the CARE project manager and the CIES program staff; between the finance departments of both organizations; and between senior management. During the difficult process of negotiating the sub-agreement and project start up activities relations at times became strained but these channels of communication were always open and utilized.

coordination meetings involving the CARE project manager, the CIES deputy project manager, the Director of Services, and the Director of the El Alto clinic are held at least once a month. The project manager also meets more frequently with the deputy project manager and the field coordinators and CBD supervisors. The first annual review and subsequent planning for the second year was done together. The staff from the two financial offices have also met formally several times to work out specific issues but do not hold regular meetings. Communication by telephone and financial transactions and reporting are more common. Interviews with both finance directors indicate that relations are good and beneficial.

There are two areas of coordination that could be improved. The first is that there does not appear to be optimum communication and coordination between the finance and project staffs within each of the two institutions. Neither CARE's project manager nor CIES's deputy project manager have received adequate training in financial management or the financial procedures of their respective organizations. They have been minimally involved in preparing and monitoring the project budgets, and in projecting and monitoring cash flows. The second area of concern is that there does not appear to be sufficient awareness and empathy regarding each organization's understanding of the other's organizational and contractual obligations, in particular CARE's responsibilities to USAID and CIES staff obligations to their organization in addition to project responsibilities. A joint workshop had been planned which would have addressed both of these issues, but it was indefinitely postponed.

4. CIEmunity Relationships

The CIES clinic in El Alto was established in 1987 and the provision of reproductive health services has steadily increased each year. CIES began a small-scale CBD volunteer program in 1988 which became the basis for an expanded program with the present child survival project. CIES appears to have good working relations with the Regional Secretariat of Health, the Municipal Government of El Alto, and numerous non-governmental organizations in the area. CIES is an active and respected member of the multi-institutional municipal health committee.

K. REFERRAL RELATIONSHIPS

1. Family Planning

The major referral site for the CBD project is the CIES clinic. However as noted above, the referrals for clinical family planning and STD/AIDs services have been less than expected. CIES tried to encourage family planning referrals by offering to pay promoters 3 BS per IUD and Pill referrals. However if the promoter accompanies the patient to the clinic, which she almost has to do in order to get credit for it, then the 3 Bs barely covers her bus fare. Suggestions have been made in this report (see section C) for improving this situation. The project also tried to stimulate referrals by having the promoters hand out CIES brochures with maps about how to get there when referring clients. Part of the problem may be that people are coming to the clinic who have been referred by a promoter but they may not be reporting this when they come. For this reason the evaluators recommended that the project use referral forms offering discounts to new patients (see section C of this report).

2. Sexually Transmitted Diseases

Patients are also referred for STD problems. However most of these have come from pap smear screening at the CIES clinic. As pointed out in section C of this report there is a general lack of knowledge about STDs in the target audience, so it will be necessary to really push STD education in order to stimulate clinic visits. We suggested above that the project consider working with PSI to develop mass media STD messages which would also refer prospective patients to CIES.

For problems that can not be handled at the CIES clinic, they have traditionally referred to the Los Andes Hospital which is located close to CIES. However, Los Andes has recently hired a priest as its director and the hospital will no longer be offering family planning services. So CIES will have to develop a new family planning referral source. Los Andes will still be a source for STDs and CDD referrals though.

3. Control of Diarrheal Diseases

The DIP states that CBD volunteers will refer acute cases of diarrhea and dehydration to the CIES clinic in El Alto. The CIES clinic services but not for the treatment of children. The clinic is, however, well staffed and equipped to diagnosis and treat mild and moderate cases of diarrhea and dehydration. There are seven health centers in the three districts comprising the immediate project area. In addition, the Regional Secretariat of Health has two hospitals in El Alto, including the "Los Andes" tertiary care hospital which can manage cases of severe diarrhea and dehydration.

When asked, the CBD volunteers recommend referrals of children to the neighborhood clinics because they are more accessible to the patients. In particular, the clinics run by PROSALUD are better equipped and known for treating children. For severe cases of diarrhea and dehydration, children are referred two the SOH hospitals in El Alto or to the Childrens' Hospital in La Paz. This child survival project has not undertaken any activities designed to strengthen the services provided by the neighborhood clinics, rather the focus is to enhance dietary management and early treatment with ORT.

L. PVO/NGO NETWORKING

1. CIES

As mentioned in section III of this report, CIES has a large network of PVO/NGO contacts in La Paz and El Alto. As mentioned above, CIES has a good relationship with several organizations working in El Alto in primary and in women's health care. These include Gregoria Apaza, CIDEM, Promujer and most recently *an NGO* run by the Dutch government. CIES is seen as a leader in the reproductive health field, so they are often looked to by the other PVO/NGO groups to provide direction or help solve problems when they arise. The CIES clinic director attends regular meetings of this PVO/NGO network.

As mentioned in section III, the one NGO that CIES does not have a good relationship with is PROSALUD which is a very big and successful primary health care organization also supported by USAID. Unfortunately efforts were not made on the part of donors to encourage a good working relationship between the two agencies. At 'one time there was a proposal for CIES to provide family planning training for PROSALUD staff as well as other collaborative efforts but this good intention quickly disintegrated when PROSALUD moved into the same districts that CIES was working in.

CIES staff also participate on five national subcommittees of the Secretariat of Health: research; services; logistics; information,

education and communication (IEC); and training.

2. CARE

CARE is a co-founder and an active member of PROCOSI, a local consortium of NGOs working in child survival. Originally established by USAID/Bolivia as a mechanism to channel funds, consolidate information and coordinate activities among NGOS, PROCOSI has grown to a membership of eight international and 16 national organizations, with a diversified budget of over $1 million annually, and notable influence in the development of national health policies and strategies. The CARE country director has been very involved in the PROCOSI leadership and is highly regarded by PROCOSI's executive director. Networking with PROCOSI members regularly takes place, both formally and informally, in La Paz and often at the regional level. The CARE reproductive health sector coordinator participates on PROCOSI's regional technical committee for La Paz.

CARE also participates on two national subcommittees of the Secretariat of Health. The child survival project manager, an epidemiologist, is a member of the subcommittee on research and the subcommittee on services.

M. BUDGET MANAGEMENT

1. Analysis of Expenditures

The total field budget for direct costs is $618,268 (USAID, $455,049; CARE, $163,219) for the three-year period. An additional $46,988 is budgeted for indirect costs of CARE Bolivia. Personnel costs represent 51.2% of all direct costs. In November 1995, USAID approved the subagreement with CIES and concurrently approved an amendment to its agreement with CARE which modified the original budget line items: $220,936 was reallocated for the CIES subagreement, and $1 was added to CARE's match. Table 1 in Annex F shows how the funds were reallocated. Of the total field budget, CIES would directly manage $216,634' (352) and CARE would manage the remaining $401,633 (65%).

Through April 1996 (month 19, 53% of the life of project), 29.5% of the field budget had been spent. In terms of the budget for the first two years (through September 1996), CARE had spent 59.49 of its portion while CIES had spent 21.32 of its portion (Table 1, Figure 1). The CIES subagreement budget only began in August 1995 (eight months running). The primary reason for the underspending was the delay in negotiating and approving the subagreement (see

[3] By the time the wbagreement was actually eigned, the amount of funde actually needed by CIES was less than that authorized.

sections J.l above and M.2 below). Another contributing factor was that neither the CARE project manager nor the CIES deputy project manager have had experience nor adequate training in budget management and have not been fully aware of available funds in each of their respective budget line items.

Figures 2-4 analyze the levels of expenditures by organization and line item. Personnel expenditures are pretty much on track for both organizations. CIES has not hired a project secretary as planned, and therefore has money to hire a driver which is more important. CARE has overspent its procurement budget by $15,132, primarily due to covering the first year costs of training and other start up needs. In May 1996, CARE headquarters held a workshop on IEC in Kenya for all CARE's child survival projects. CARE Bolivia was not aware that there were funds available in this project for this activity and no one was sent. The large balance of funds in the "Consultants@@ line item will be utilized for the mid-term and final evaluations, as well as for assistance in developing education and training materials.

A number of purchases for office equipment and furniture and training costs were being processed and were not yet registered in the financial reports. Nevertheless, CIES should have ample funds in its "Procurement" line item to cover those recommendations it chooses to implement, including mass informational activities and the purchase of needed supplies of printed materials for distribution. With strategic planning and astute management, it is very likely that both CIES and CARE will be able to use all available funds in the project. CARE's budget will have to be readjusted to reconcile the over-expenditure in CXES should also begin drawing down on its "Indirect Cost" line item.

2. Disbursements and Reporting

Between January and July 1995, CARE directly paid for CIES costs in order to initiate staff and CBD volunteer training. This was at a slower pace than initially planned, however, because 1) the extended negotiating of the subagreement took time and energy away from implementation, and 2) the process of disbursing funds to CIES on an item-by-item basis was inefficient. This latter practice continued until April 1996 (the subagreement was signed by CARE and CIES in late February) when CIES received its first major advance.

CARE advances funds to CIES monthly based on need projections. A new disbursement is authorized when at least 70% of the previous disbursement is accounted for. The CARE project manager, in consultation with CIES, makes quarterly cash flow projections in accordance with CARE policy. The CARE finance department has provided assistance to its CIES counterpart regarding USAID Standard Provisions, purchasing and documentation requirements, and

reporting formats. The two departments admit to working well together. The major deficiency is that the CARE project manager and the CIES deputy project manager have not been fully involved in financial management and budgeting monitoring practices. Training is being planned for both people.

CIES currently receives funding from a variety of sources including USAID/Bolivia and other USAID contractors (IPPF, PSI, FHI, and PROCOSI). In 1995, CIES was using a manual accounting system for the CARE project because the finance department could not program its computerized system (Tech-Apro) to produce reports in the CARE account codes. CARE subsequently provided CIES with another system which would meet CARE's accounting and reporting requirements. At present all of CIES accounting is done on the Tech-Apt0 system; the CARE subagreement project is also processed in the CARE-donated system. This double accounting and reporting requires about 15% FTE extra staff time at CIES. Apparently this practice will continue until CIES can program the Tech-Apro system to process and report in the CARE account codes.

3. Pineline Analvsis

The Country Project Pipeline Analysis is presented in Annex F.

v. SUSTAINABILITY

The most important and promising part of the sustainability strategy for this project is the subagreement by which CIES, a Bolivian NGO, assumes full responsibility for implementing the field activities. CIES not only collaborated in the initial design of the project and jointly with CARE prepared the DIP, but by virtue of the subagreement was provided with the funds to hire all project field staff, with the exception of the CARE project manager, and carry out all project activities.

The following table outlines the sustainability objectives and outcomes. This table is not an official statement of the project design but rather the evaluators' perception of project status.

Sustainabiljtv Goals. **Objectives. Mid-term Measures and Stem Taken and Needed**

Goal	End of Project Objectives	Steps Taken to Date	Mid-Term Measure	Steps Needed
A) **CIES** assumes full responsibility **for project** irnplomcntation.	1) **CIES** will develop and **carry** out pmjcct implementation plan.	**1) Subagreement approved and signed; 7 staff trained;** aclivilіu initiated.	**1) Process delayed but objective achieved.**	**1) Accelerate activities to make up for lost time.**
	2) CIES will **execute** and accounl **for** approved pmjcct budget **expenditures.**	**2) Initial funds transferred; accounting and reporting practices agreed on.**	2) 21% of funds **expended and reported; procedures in place.**	**2) Accelerate expenditures by implementing** recommendationa.
B) Women and men, 15-49 years, will continue to demand family planning, STD and **CDD/ORT services and supplies.**	**1) CIES will provide community-based promotion and education** activitia.	**1) 111 promotional activities in 26 neighborhoods; 202 educational** activilia in **25** neighborhooda.	**1) No targets for promotional and educational activities; activities not** equitably distributed.	**1) Target promotional and** educational aclivitieș in **underserved zones.**
	2) Local maxs media will **transmit** puhiic awareness and iinformalion mange3 of **FP, STDs** and **CDD/ORT.**	**2) Informational flyers distributed** in **20% of project area;** no mall media rpb develop4 hy **project.**	**2) No targets** ret; mass media not contcmplatd in DIP.	**2) Produce and distribute more** printed **materials; develop and transmit mass media messages.**
C) CBD volunteers and the CIES clinic will continue to provide quality FP, STD and CDD services and **supplies.**	**1) CIES will supervise and provide refresher training for 125 CBD volunteers.**	**1) 88 volunteers trained and active; 36% retention rate.**	**1) 100 volunteers trained in all three components; 50% retention rate.**	**1) Select, train and retain 37-62 new CBD volunteers;** jincrease **retention rate** to 50%.
	2) **CIES** will **obtain** and distribute sufficient mupplics of contraccptivcr and **ORS packets.**	2) 8,882 new **CIES users of contra-ceptives;** no data on **ORS users.**	2) new **users data** is **unclear;** nix **month supply of ORS obtained.**	**2) Obtain and** ,maintain at **least 8,640 users;** ,dirtributc at lurt **13,500 ORS packets per year.**

VI. RECOMMENDATIONS

1) Do not expand project to rural communities at this time. (Will need written approval from USAID if this decision is taken by the project). Study the options of expanding to rural areas and/or to growing marginal areas of El Alto during the next three months as alternatives for a project extension proposal which will be developed in October.

2) Provide training for CIES personnel in:
- methods and techniques of constructive Supervision;
- human relations and personnel management;
- operational planning;
- data analysis for decision making; and,
- social marketing techniques to increase CBD sales;

3) Provide training in financial management and budget control to the CARE project manager, the CIES deputy project manager, Director of Services and the Director of the El Alto clinic. Also provide training to the new CIES accountant regarding CARE procedures and reporting formats. The-'CIES deputy project manager and CARE project manager should receive monthly financial statements of project movement in order to facilitate their programming responsibilities.

4) Produce greater supplies of CIES promotional pamphlets and educational brochures for family planning, reproductive health, STD prevention and treatment, and diarrhea1 disease prevention and ORT for use and distribution by CBD volunteers and project staff. Also order referral forms to be used by promoters. Family planning, reproductive health, and STD prevention print materials can be ordered through the JHU/PCS office (IEC subcommittee). Pamphlets about STDs and AIDS are also being developed by PSI. Suggest reviewing PRCJCOSI materials in order to find suitable handouts about CDD.

5) For community education: (see discussion - section C)

- Revise and limit amount of information transmitted to low literacy audiences. 5 to 6 messages that can be repeated and discussed per session. Develop written guidelines for this.
- Incorporate more participatory techniques in sessions.
- Provide "Capacitando sin Letras" training to staff
- Provide strong field supervision and follow-up to staff and volunteers for community education.
- Arrange for regular technical reviews and updates for both staff and volunteers.
- Develop promoter manual for STDs and CDD. Make additions to Family planning manual as needed.
- Clarify *family* planning standards of care with CIES medical staff and review standards with project staff.

6) Recommend that the project contract a health education Consultant to develop community level modules that have been recommended in section C of this report. These modules are to *Serve* as guidelines for specific messages to be taught to community groups.

7) Prominently show the CIES and reproductive health logos on all educational and promotional materials. Provide active promoters with plaques for their homes/shops that identify them as being both CIES and reproductive health volunteers. supply them with hats and/or other apparel that strengthen their CIES/ Reproductive Health Promoter identity.

8) Reorganize the supervisory responsibilities of the CBD supervisors by: 1) concentrating the CBD volunteers that they supervise in contiguous zones; and, 2) eliminating house-to-house promotional visits thereby allowing more time for promotional activities at fairs and markets, and more time devoted to follow-up of active and inactive volunteers.

9) Restructure the field team to provide for enhanced leadership and planning capabilities and a greater coordinator to supervisor ratio. Current roles are not sufficiently differentiated; one effective coordinator should be able to supervise four or five CBD supervisors; perhaps one person should be responsible for planning and organizing all community education and/or volunteer training activities. Suggest that the project consider establishing a field director position directly under the assistantprojectmanager who develops field strategy, provides leadership, on the job training, and develops staff field skills in family planning, STDs and CDD. This person could also balance strategies for reaching both CBD and clinic objectives that are influencing the project.

10) Resolve transportation problems that staff have in covering field area. There are several options for this in the project budget. One is to hire a driver for the CBD program vehicle in El Alto using the funds allocated for the unfilled position of project secretary. This would greatly alleviate the current transportation difficulties and decrease travel time and cost of the CBD supervisors and coordinators to the project neighborhoods.

11) Increase the target number of active promoters to be recruited by the project to 150 (instead of 100). This may require greater recruitment and training efforts and/or more thorough promoter retention strategies.

12) Plan future promotional and community educational activities in order to strategically cover currently underserved areas. Also, select and train new volunteers from currently underserved areas. These three activities should be linked strategically for maximum effectiveness.

13) Continue the current practice of having supervisors provide one half day per week at the CIES clinic, but organize this half-day to include less counseling and more of the following functions: control of referral slips to assure volunteer recognition and incentives; promote quality assurance for referral patients including translations when necessary; documentation of previous week's activities; planning of subsequent weeks activities; and, providing contraceptives and ORS packets to volunteers.

14) Hold regular monthly meetings with. CBD volunteers, by geographic areas. These meetings would be facilitated by the area supervisor with the coordinator in attendance. (Meetings for the different supervisors and their volunteers would be held on different days or weeks of the month so that the coordinator would be able to attend all meetings.) The purpose of the meetings would be to identify and discuss common problems; provide refresher training and share innovative approaches on specific topics; collect monthly reports; plan the next months educational and promotional activities; and to develop a mutual support network among the volunteers. Due to difficulty in getting promoters to come to monthly meetings, would recommend use of project funds to pay transportation costs and provide refreshments.

15) Hold regular meetings, perhaps quarterly, between the project manager, the deputy project manager, and the directors of both finance offices to discuss and resolve financial management issues.

16) Re-schedule as soon as possible the inter-institutional workshop to discuss the roles, responsibilities, obligations and procedures of the program and financial departments of both institutions in order to enhance mutual awareness, support and coordination.

17) Schedule regular meetings between clinic and CBD staff in El Alto in order to improve awareness, expectations and coordination of activities. Field director needs to be involved in bridging the different goals and expectations of the CBD program by Clinic staff, on the one hand and project personnel on the other.

18) Prepare accurate maps of the project areas to facilitate programming and evaluation of coverage. These maps will also be very useful in designing an extension project. The maps should identify, actual roads, settled residential areas (blocks), the precise location of parks, schools, health posts, churches, factories, community meeting halls, and other key points of orientation. Current information may be obtained from the Military Geographic Institute, the urban

planning department of the city of El Alto, and the census maps of the National Statistics Institute. Volunteer or low cost assistance in preparing the maps may be obtained from university students (thesis projects), or Peace Corps volunteers.

19) Develop mass media spots or take advantage of spots being developed by other programs for, local radio, television and newspapers for the STD/AIDS and CDD/ORT components in order to reinforce messages and expand exposure in the general population. The spots should focus on a few messages for prevention and early diagnosis, as well as direct the audience to services offered by CIES. Solicit assistance from the PSI and **JHU/** PCS projects, and also review PROCOSI experiences in order to reduce communications development costs. PSI has an agreement with CIES to strengthen its IEC capabilities, and has also developed radio spots about prevention of STDs and AIDS which could be made use of.

20) Add practical experiences such as role playing in marketing and sales to the basic family planning course for new CBD volunteers. Practice sessions concerning how to sell methods, how to interest clients, how to deal with resistance etc. would allow new promoters to feel better prepared for the job. Could ask PSI to help with this training since they have trained promoters to market their products.

21) In order to encourage better method mix the project staff needs to stimulate more demand for hormonal methods and for the IUD. At present, CBD staff prefer barrier methods. Suggest that staff and CBD volunteers be given more follow-up education about hormonal and IUD methods, so that they are more comfortable promoting them. Should also explore more or better incentives for promoters who refer patients to the clinic for these methods. Consider allowing promoters to distribute first two cycles of pills before patient has check up at the clinic.

VII. SUMMARY

The evaluation team is composed of Sandra Wilcox, consultant and evaluation chief of party, Jim Becht, CARE Regional Technical Advisor, and Miryam Wolfenson, facilitator. The team spent a total of 22 days on the midterm evaluation activities, except for Miryam Wolfenson who spent 7 days, mainly in evaluation planning and workshop preparation activities. Five days were spent on field visits and in interviews with project and institutional personnel. Two days were spent initially in team planning and interview preparation activities. Questionnaires were developed for project staff interviews, lists were developed of potential promoter

interviews along with maps of their locations. Results of the findings and recommendations were presented to the two participating organization (CIES and CARE). Sandra Wilcox and Jim Becht are the authors of this report.

One of the major accomplishments of the project has been the very innovative organizational arrangements for conducting a child survival project. This was the first time that CARE Bolivia has subcontracted a project like this to a local NGO. Both institutions have been enhanced by the relationship.

In general it seems that the project is making good progress towards fulfillment of its objectives. It is on target in meeting the outputs and process indicators outlined in the DIP. Although the project had a late start due to late approval of the subagreement by AID and delays in promoter recruitment, it appears to be catching up and making good progress at this time.

Due to the delays and the tremendous amount of work to be accomplished in the growing project area during the remaining 15 months, the evaluators have recommended that the project not distract its efforts by trying to expand into an undetermined rural area at this time. As it is the evaluation is recommending that the project expand its efforts in the existing project area to cover demand, by recruiting more promoters.

Even though at this point the budget appears to be underspent, there is every reason to believe that it will be spent by the end of the project. As noted above with the delayed approval of the subagreement, the project is recently making planned procurements, and will continue to spend in areas of training and personnel. It is anticipated that with the money remaining in the budget, project personnel will have the financial resources needed to implement the proposed recommendations.

ANNEX A

EVALUATION METHODOLOGY

CARE - CHILD SURVIVAL X - PN 26
MARKET NETWORKS FOR COMMUNITY HEALTH
MID-TERM EVALUATION
SCOPE OF WORK
(Jennifer Luna - April, 8 1996)

Evaluator: Sandra Wilcox

Purpose:

Work as team leader and be in charge of the mid-term evaluation of the project Market Networks for Community Health (PN-26) which is financed from AID/Washington Child Survival X funds. Sandra Wilcox is responsible for writing the final *evaluation* document.

The final evaluation document will be written following AID/W's guide for mid-term evaluation of CS X funded projects.

Dates: In Bolivia, June 1-22 with 1 day of preparation before the trip. See attached *chronogram* for dates of specific activities.

Specific Tasks:

- Organize the work of the evaluation team through planning specific topics to explore through interviews, design of evaluation instruments, determination of information and documents that CARE and CIES should provide. This work will begin during the team planning meeting facilitated by Myriam Wolfenson which will take place on June 3rd and 4th.

- Maintain coherence in the evaluation team member's work .

- Evaluate technical aspects of the following components: Family Planning, STD/AIDS prevention, personnel and volunteer training, IEC and CARE-Bolivia and CARE-Atlanta backstopping.

- In coordination with the other members of the team, determine the division of work regarding specific topics and questions to ask and areas to evaluate.

- Visit the project.

- Interview key personnel in CARE and CIES.

- Present the results of the evaluation to CARE and CIES during a formal meeting which will be facilitated by Myriam Wolfenson on June 18th.

- Write the final version of the evaluation report in English following AID/W's guide for Child Survival X and including data and instruments used.

Specific topics and questions to be addressed:

- The evaluation will include the following topics which are described in the AID/W guide for mid-term evaluations of Child Survival IX (the guide for X is not available yet).

  - ♦ Project design and response to technical comments.
  - ♦ Information system.
  - ♦ Human resources.
  - ♦ Supplies for project personnel.
  - ♦ Supervision.
  - ♦ Use of technical assistance.
  - ♦ Relation between CARE and CIES.
  - ♦ Referral system.
  - ♦ Collaboration with other institutions.
  - ♦ Budget management.
  - ♦ Sustainability.

- If the number and type of personnel is adequate in order to reach project objectives.

- If CARE's structure is adequate in order to ensure coordination between programmatic management and funding flow from CARE to CIES for project use. Suggestions for improvement should be provided if needed.

- If a follow on project, based on the current project, is desirable after this project ends and what interventions should be included in the second project.

- Other questions which are included in the guide for Child Survival X.

- Other questions that arise from CARE and CIES before the beginning of the evaluation work.

ANNEX B

LIST OF DOCUMENTS REVIEWED

LIST OF DOCUMENTS REVIEWED BY THE EVALUATORS DURING THEIR WORK ON THE MID-TERM EVALUATION OF PN-26

A Child Survival X
Market Networks for Community Health
First Anual Report
Altiplano Region, Bolivia
October 1, 1994 - September 30, 1995
FAO - 0500- A - 00 - 4037 - 00

A CARE in Bolivia
Detailed Implementation Plan
Child Survival X
Market Networks for Community Health
El Alto, Bolivia
October 1, 1994 - September 30.1997
Cooperative Agreement No. FAO 0500 - A -00 - 437 - 00

A Lessons Learned From
The Experience of Indirect Project Implementation
Through a Partnership with CIES,
a Local Bolivian NGO
CARE - Child Survival X - PN-26
Market Networks For Community Health
Prepared by: Jennifer Luna
Project Manager, March 27, 1996

▲ CARE - Supervivencia Infantil X - PN-26
Redes Comerciales para la Salud Comunitaria.
Plan de Trabajo para el Sistema de Información en Salud
Del Proyecto de DCA en El Alto
(Jennifer Luna - 10 de Abril de 1996)

A CARE - Supervivencia Infantil X - PN-26
Redes Comerciales para la Salud Comunitaria
Resumen de la Reunion Tecnica entre CARE y CIES
(Jennifer Luna - 12 de Abril de 1996)

A CARE - Supervivencia Infantil X - PN-26
Redes Comerciales para la Salud Comunitaria
Resumen de la Reunion Tecnica entre CARE y CIES
(Jennifer Luna - 17 de Abril de 1996)

A CARE - Supervivencia Infantil X - PN-26
Redes Comerciales para la Salud Comunitaria
Resumen de la Reunion Técnica entre CARE Y CIES
(Jennifer Luna - 18 de Abril de 1 QQ6)

A CARE - Child Survival X PN-26
Market Network for Community Health
Project Implementation Report (FY '95)
(Jennifer Luna, Project Manager PN-26, August 28, 1995)

A CARE - Supervivencia Infantil X- PN-26
Redes Comerciales para la Salud Comunitaria.
Resumen de la Reunion de Coordinación entre CARE y CIES
(Jennifer Luna - 9 de noviembre de 1995)

A CARE - Child Survival X PN-26
Market Networks for Community Health
Project Implementation Report
First Quarter, FY '96 (July - September 1995)
(Jennifer Luna Project Manager PN-26, December 6, 1995)

A Carta - Respuesta a la Revision Técnica del DIP
del señor Alfred0 Machicao al
Doctor José Luis Duefias al
Director de Servicios del CIES
(La Paz 12 de septiembre de 1995)

A Memorándum - Respuesta a la Reunión Técnica del DIP
Para el doctor José Luis Duefias
Director de Servicios
de la Doctora Carmen Monasterios
Responsable National de DCA
Asunto: Revision de Comentarios del DIP- El Alto.
(La Paz 11 de septiembre de 1995)

A Informe de Trabajo de Campo
(Zona Brasilia y Vivienda del Distrito I)
Maria Dolores Castro y Juana Huanca

A Informe de trabajo de Campo No. 2 de
Maria Dolores Castro y Juana Huanca

A Informe de Trabajo de Camps #1
Maria Dolores Castro y Juana Huanca
19 de Diciembre de 1995

A Perfil de Investigación
Conocimientos, attitudes y prácticas tradicionales acerce
de Planificacion familiar (PF) Enfermedades de
Transmisión Sexual (ETS) y Enfermedades
Diarreicas Agudas (EDA), en áreas urbano
marginales de la ciudad de El Alto (Distrito I y II)

A CIES Mbdulos Educativos
Dirección de Educacibn y Capacitation
CIES 1995

A CARE - Child Survival X PN-26
Market Networks for Community Health
Project Implementation Report
Second Quarter FY '96
(October - December 1995)
(Jennifer Luna, Project Manager PN-26, January 22, 1996)

A CARE - Child Survival X PN-26
Market Networks For Community Health
Project Implementation Report
Thrird Quarter, FY '96 (January - March 1996)
(Jennifer Luna, Project Manager PN-26 April 26, 1996)

A Memorandum a Mary Vandenbroucke
Gerente Salud Reproductiva
A: Jennifer Luna, Gerente PN-26
Tema: Informar Financiera del PN-26
La Paz, 24 de Mayo de 1996

A Memorandum A: Mary Vandenbroucke
Gerente Sector SR
De: Hugo Del Pozo, Gerente Finanzas National
Ref: Confidential Asesores No. 035
Asunto: Information PN-26
La Paz, Junio 05 de 1996

A Memorandum A: Hugo Del Pozo
Gerente National de Finanzas
De: Jennifer Luna, Gerente PN-26
Asunto: Trabajo entre los departamentos de Finanzas
de CARE y CIES.
La Paz 9 de Febrero de 1996

A Memorandum A: Jennifer Luna, Gerente PN-26
De: Hugo Del Pozo, Gerente de Finanzas
Ref: Manejo Financier0 CARE-CIES
La Paz, 12 de Febrero de lQQ6

A Observaciones y Puntos de Discusibn
para el Proyecto de El Alto
Jayne Lyons, Octubre 1995

▲ CIES - Proyecto DCA
El Alto Informe del Taller de
Autoevaluacion Mayo, 1996

A CIES - Resumen de Reclutamiento de Voluntarios para et Segundo año. Preparado por Carmen Monasterios (Enero 4 de lQQ6).

A Subconvenio entre CARE-Bolivia y CIES

A Secretaria Regional de Salud El Alto, Distrito I (Alto Norte),
Imformacion por Areas de Salud Gestion 1995.

A Secretaria Regional de Salud El Alto. Distrito II (Alto Centro).
Información del Area de Salud Villa Avaroa, Gestion 1995.

A Bibliografia - Secretaria National de Salud. SNIS, Estadisticas de Salud 1994

A Del Pozo, Hugo. Lecciones Aprendidas; Trabajo en Asociación.
CARE-Bolivia, Memo to Eddy Ochoa, Mayo 5, 1996.

ANNEX C

LIST OF PERSONS CONTACTED/INTERVIEWED

LIST OF PERSONS INTERVIEWED FOR THE MID-TERM EVALUATION OF PN-26

Lit. Hugo Del Pozo	Finance Department Manager
Lit. Kirsten Johnson	Assistant Country Director (CARE)
Lit. Mary Vandenbroucke	Reprodudive Health Sector Manager
Lit. Jennifer Luna	Project Manager, PN-26 (CARE)
Lit. Nancy Castellón	Johns Hopkins/PCS
Lit. Ariel Perez	Johns Hopkins/PCS
Lit. Esteban Umerqut	PSI
Dr. Alfredo Machicao	CIES
Dr. José Luis Dueñas	Services Director, CIES
Lit. Delia Ovieclo	Finance Director, CIES
Lit. Cecilia Huasebe	Training and Education Director
Lit. Maria Eugenia Lopez	In Charge of Training, CIES
Lit. Ivan Prudendo	Executive Diredor. CIES
Dra. Carmen Monasterios	National Head of C.B.D.. CIES
Lit. Amparo Aliaga	In Charge of STD/AIDS, CIES
Matilde Sanchez	CBD Projed Coordinator, El Alto, PN-26. CIES
Carmen Rosa Mamani	CBD Project Coordinator. El Alto, PN-26, CIES
Belia Cuba	CBD Projed Supervisor. El Alto, PN-26, CIES
Adela Rios	CBD Project Supervisor, El Alto, PN-26. CIES
Adela Paredes	CBD Projed Supervisor, El Alto, PN-26, CIES
Celia Pacari	CBD Project Supervisor. El Alto, PN-26. CIES

interviews with Volunteer Promoters, CBD Project. El Alto. PN-26

Name	Neiahbomood
Jesus Tambo	Dolores F.
Luisa Mamani	Pacaye Calullo
Lourdes Tiana	Cosmos 77
Irma Saavedra Vda. de Undo	July 16th
Wilson Tarqul Ayala	Eduardo Abaroa Dolores F.
Kataiina Rodriguez	Franz Tamayo
Angélica Luna	Pedro Dom. Murillo
Josefina Quispe	July 6th
Irene Floras	Pedro Dom. Murllio S-2
Ester Mariaca	Brasii C Street
Leonor Alabia	May 1st, 380
Corina Junco	Villa Adeia. 241